

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	2	1	1	2	2
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
WILLIAM ERNEST BAILEY						AUGUST 31, 1982						a.m.						
3. SEX Male			4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 27, 1916			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil											
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver			12b. KIND OF BUSINESS OR INDUSTRY Alger Oil Co						
13. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 136 Providence Road										
14. FATHER'S NAME FIRST William			MIDDLE T.		LAST Bailey		15. MOTHER'S MAIDEN NAME FIRST Henrietta			MIDDLE B.		LAST Purdy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 218-18-1820			17. INFORMANT Mrs. Gladys M. Bailey, Elkton, Md.			ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 days 2 years						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic obstructive lung disease																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21a, PART 1 OR PART 2)												
22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.			22c. LOCATION STREET			CITY OR TOWN									
22d. I certify that (I) (we) attended the deceased from now the deceased alive on 8-30 1982 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.												19 82 to 8-31 19 82						
22e. SIGNATURE Donald C. Edgren M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 8-31-82									
22g. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD C. EDGREN M.D.			22h. ADDRESS 721 Bridge Street, Elkton, Md. 21921															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-3-82			23c. NAME OF CEMETERY OR CREMATORY Zion Meth. Cemetery			23d. LOCATION CITY OR TOWN Cecilton, Maryland			COUNTY STATE						
24. FUNERAL DIRECTOR NAME Donald S. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.						25a. DATE REC'D. BY REGISTRAR SEP 9 1982			25b. REGISTRAR'S SIGNATURE John G. Coughlin									



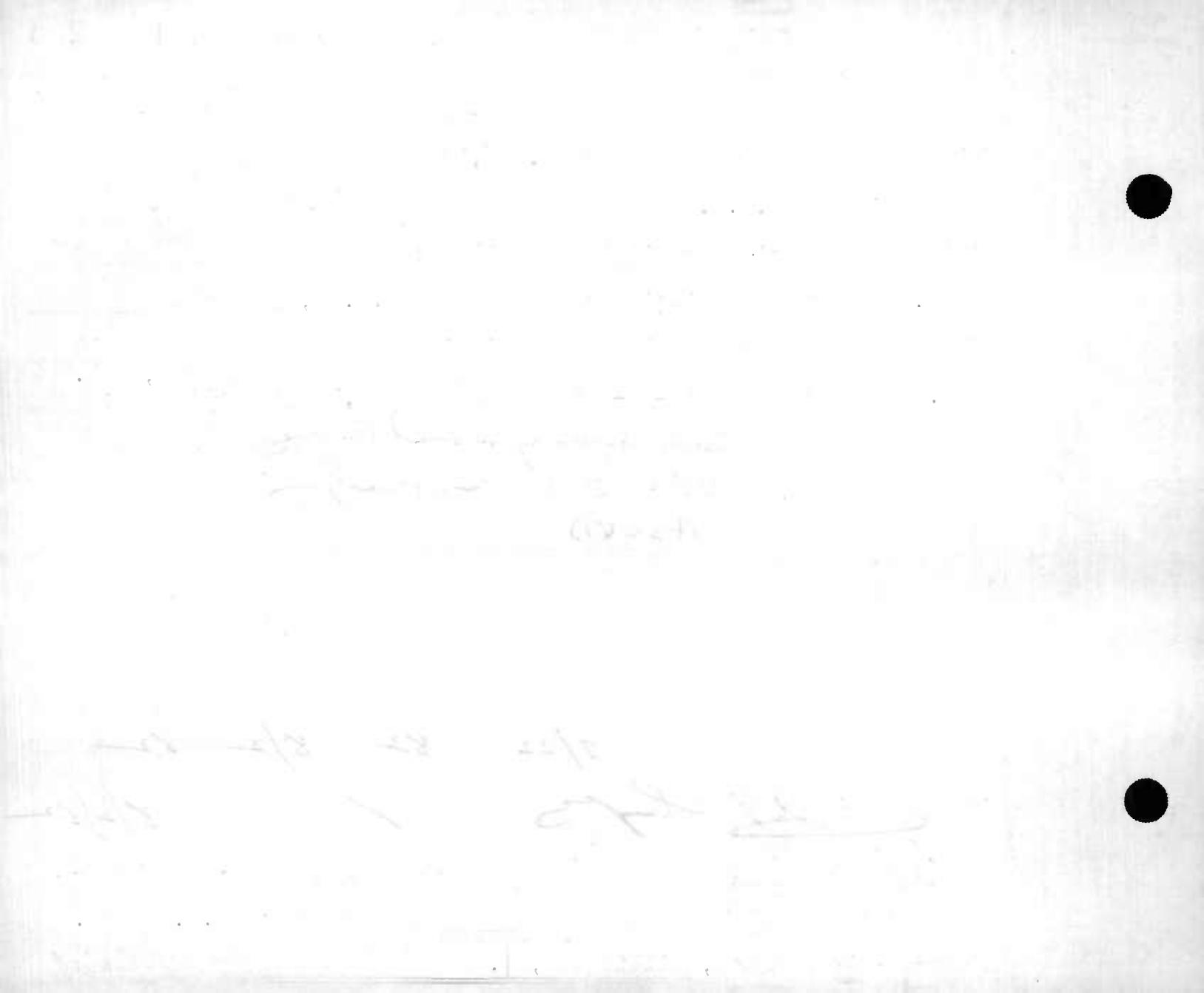
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows a single injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82 21123					
												REG. NO.					
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)			LAST			8/2/82 110 P.M.			IF UNDER 1 YEAR		IF UNDER 24 HRS						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		8. UNDER 24 HRS					
Male		White		Sept. 16, 1895			86			YRS.		MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
Indiana		U.S.A.					Cecil Co.			Elkton							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								12b. KIND OF BUSINESS OR INDUSTRY					
Union Hospital of Cecil Co;				Md. STATE Md. COUNTY Kent								Management Engineering					
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13b. STREET ADDRESS R.D.#1, Box 295 A								14. FATHER'S NAME FIRST MIDDLE LAST					
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes. WW 1				14b. SOCIAL SECURITY NO 299-01-9915								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Campbell					
16a. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292				16b. DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. & (c) Heart paralysis								16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)																	
17. DUE TO, OR AS A CONSEQUENCE OF (c) A.S.E.D.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
18a. MEDICAL CERTIFICATION				19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				22a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				22b. SIGNATURE E.H. Phillips DEGREE					
22a. I certify that (I) (this hospital) attended the deceased from 7/22, 1982, to 8/2, 1982, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I did) (did not) view the body after death.														22c. DATE SIGNED 8/2/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22f. DATE SIGNED					
Ernesto Ab Lang M.D.				EIKTON, MD 21921													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				8/5/82				Crumpton Cemetery				Crumpton Q.A. Md.					
24. FUNERAL DIRECTOR NAME Edward Fellows & Son, Millington, Md.				ADDRESS 21651				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE AUG 9 1982 John J. Carroll					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3221124					
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR		2b. HOUR			
			Harry			M. Battersby, Jr.			<input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>			8 13 1982		116 P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. DATE			
Male		White		MONTH DAY YEAR		LAST BIRTHDAY		MONTHS DAYS		HOURS MIN.		MONTH DAY YEAR		2d HOUR			
10a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10b. CITIZEN OF WHAT COUNTRY?		10c. DATE OF BIRTH		10d. AGE (IN YEARS)		10e. MARRIED		10f. NEVER MARRIED		10g. WIDOWED		10h. DIVORCED		10i. BALTIMORE CITY OR COUNTY OF DEATH	
Phila. Pa.		USA		6 30 20		62 yrs.		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Cecil	
10d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital of Cecil Co.									Funeral Director					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Arizona			Maricopa			Phoenix			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			1348 E. Missouri Avenue					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
FIRST Harry M. Battersby			FIRST Louise			16b. SOCIAL SECURITY NO. 177-14-9035			17. INFORMANT Miss Gwendolyn Battersby			ADDRESS Phoenix, Arizona					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: 5712 IMMEDIATE CAUSE (a) <i>Upper Gastrointestinal Hemorrhage</i>																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Cirrhosis of the liver</i>																	
(c) <i>Chronic alcoholism</i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. TITLE (SPECIFY) M.D. <i>Deputy</i>			22c. MEDICAL EXAMINER			22d. DATE SIGNED <i>8/13/82</i>								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			EXAMINER'S ADDRESS			EXAMINER'S ADDRESS			EXAMINER'S ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY					
Burial			8-18-82			West Laurel Hill Cemetery, Elkton, MD			Baltimore County, Maryland								
24. FUNERAL DIRECTOR NAME <i>Talph E. Hicks</i>			ADDRESS			25a. DATE OF BIRTH (BY DEATH YEAR AND REGISTRATION NO.)			25b. DATE OF DEATH (BY DEATH YEAR AND REGISTRATION NO.)								
HICKS HOME for FUNERALS, ELKTON, MD.						1918			1918								

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## MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE  
HEALTH DEPT.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201  
 2. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours  
 3. after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1b, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5, if Pages 5 may be retained for your files.

10. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and file any event within 72 hours after death.

11. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL

12. VITAL STATUS (S) BM-1/70

1. DECEASED-NAME (Type or Print)	First Karen	Middle Lee	Last Benson	2a. DATE KNOWN OF DEATH ESTIMATED MATED	Month 8	Day 23	Year 1982	2b. HOUR M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4-22-65	6. AGE (in years lost birthday) 17 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	MIN 0	2d. HOUR P		
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH CECIL	2c. DATE PRONOUNCED DEAD Month 8 Day 23 Year 1982				
10. CITY OR TOWN OF DEATH Earleville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At 282 Et Archery		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY CECIL	13c. CITY OR TOWN CECILTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 275 N. BOHEMIA Ave.					
4. FATHER'S NAME BARRY	First NMN	Middle BENSON	Last	15. MOTHER'S MAIDEN NAME AGNES	Middle	Last AKIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. —	17. INFORMANT 212-86-2354 PARENTS - SAME	ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8159 IMMEDIATE CAUSE (a) Fracture of cervical spine Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Motorcycle accident DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM 8 23 1982	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Subject was thrown off motorcycle that crashed						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Road	21f. LOCATION Street or R.F.D. No. At 282	City or Town Earleville	County Cecil	State MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22b. DATE SIGNED 8/23/82	
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8-26-82	23c. NAME OF CEMETERY OR CREMATORIAL CECILTON ZION	23d. LOCATION (City or Town) CECILTON	(County) Cecil	(State) MD				
24. FUNERAL DIRECTOR EDW. FELLOWS & SON	ADDRESS Cecilton MD	25a. REC'D BY REGISTRAR DATE SEP 7 1982	25b. REGISTRAR'S SIGNATURE 						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 1 1 2 6				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
F. M. PRICE					BLACKSON	08-07-82						11:03 A M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White			MONTH July DAY 17, 1913 YEAR			69			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS		
Maryland			USA						Cecil Co			DAYS		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital						Foreman-Elk Paper Co.			MD.		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland			Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2895 Singerly Road				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST					
			George	-	Blackson	Louella			Stricker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			216-03-7853			Mrs. Eleanor Blackson, Elkton, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4100 Prob. Acute myocardial infarction										immediate				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b)				
										DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 11</u> , 19 <u>82</u> , to <u>Aug 8</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>July 20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Victor M. Magalang, M.D.</i>										DEGREE				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Victor M. MAGALANG, M.D.</i>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>		
22e. ADDRESS <i>62 N. CHAPEL ST., NEWARK, DE 19711</i>										22f. DATE SIGNED <i>08-08-82</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>8-11-82</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Cherry Hill Methodist</i>			23d. LOCATION CITY OR TOWN <i>Cemetery</i>					
Burial									COUNTY <i>Cherry Hill, Md.</i>					
24. FUNERAL DIRECTOR <i>Hicks Home for FUNERALS</i>			ADDRESS <i>ELKTON, MD.</i>			24a. DATE RECEIVED FOR REGISTRATION <i>AUG 15 1982</i>			24b. REGISTRATION NUMBER <i>8-15-82</i>					

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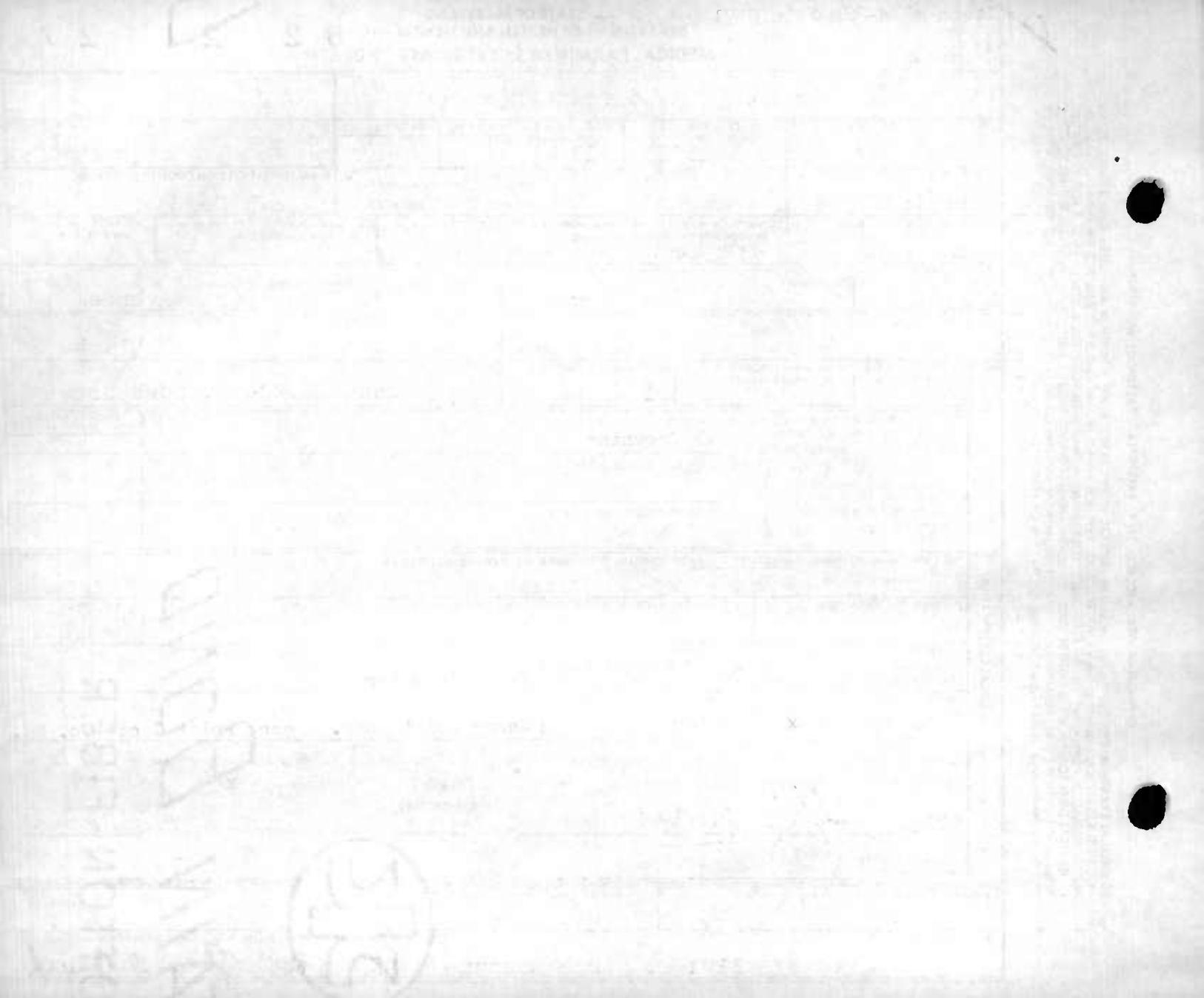
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Glossary 21

• 11 •

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE DEATH MATED	KNOWN <input type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
Lamont			Vincent			Bland						xx 8	24	1982	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONONCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
black	male	5 15 55	27 yrs.							8	26	1982	12:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		USA			XX			Cecil County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Perry Point		Perry Point Medical Center														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Maryland				Baltimore		XX		900 Bonaparte Avenue								
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME								
Ralph						Bland Sr.		Eleanir								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
Yes		615-60-0779		Ralph		Bland Sr. 900 E. Bonaparte										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  9840 IMMEDIATE CAUSE (a) Drowning												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF  (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8/24/1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found in water						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water		21f. LOCATION STREET Perry Point Hosp.		CITY OR TOWN Perry Point		COUNTY Cecil Co.		STATE Md.						
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>														
ACTUAL SIGNATURE  Hormez R. Guard, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street, Balto., MD 21201														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/31/82		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.		23d. LOCATION CITY OR TOWN Balto.		COUNTY		STATE Md.						
24 FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue		ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 1 1982		25b. REGISTRAR'S SIGNATURE John J. Conley										
BP		DHMH 8/16														
(VR A15 ME (5))		20M 4/82														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 1 1 2 8
				REG. NO.
1. FOR STATE REGISTRAR	MIDDLE		LAST	
1. DECEASED NAME (TYPE OR PRINT)	Mabel M. Buchanan			2a. DATE OF DEATH MONTH DAY YEAR 8/15/82
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 3, 1896	6. AGE (IN YEARS LAST BIRTHDAY) 86 yrs	7b. HOUR 7:00 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co.	10. CITY OR TOWN OF DEATH Elkton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST William		MIDDLE -	LAST Hamilton	15. MOTHER'S MAIDEN NAME FIRST Reba
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-52-2142	17. INFORMANT Mr. Harold G. Buchanan, Elkton, Md.	ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C-V Disease DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days Over 1 yr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Belated Doctor's visit				
19a. DATE OF OPERATION 7/21/82	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of 1st finger & 1st toe		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:15 (P.M.) 7 16 1982	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Fall on Nursing Home Porch		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Nursing Home	21f. LOCATION STREET 247 E Main St.	CITY OR TOWN Elkton	COUNTY Cecil STATE Md.
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 15</u> 1982, to <u>Aug 15</u> 1982, that (I) (we) did not see the deceased alive on <u>Aug. 15</u> 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Ralph Andrews, M.D.		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/17/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Andrews, M.D.		22e. ADDRESS 237 E. Main St., Elkton, Md. 21921		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-18-82	23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Methodist	23d. LOCATION CITY OR TOWN Cemetery, Cherry Hill, Md.	23e. COUNTY Cecil STATE Md.
24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.	ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 23 1982	25b. REGISTRAR'S SIGNATURE John J. Cawie



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 1 1 2 9
1 - FOR STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT)		REG. NO. 8 2 2 1 1 2 9
ANNA		A. BURNS		2a. DATE OF DEATH AUGUST 23, 1982
3. SEX <b>Female</b>		4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DECEMBER DAY 2, 1896 YEAR	2b. HOUR a.m.
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>
12a. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Elkton</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>
14. FATHER'S NAME FIRST <b>William</b>		MIDDLE <b>A.</b>	LAST <b>Ashby</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>164-16-2713A</b>		17. INFORMANT ADDRESS <b>William H. Stroud, Elkton, Md. 21921</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASHD - Ca Bowel</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>8/23/82</b> to <b>8/23/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.				
22b. SIGNATURE <i>Joseph G. Lanzi, M.D.</i>		DEGREE	22c. DATE SIGNED <b>8-25-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph G. Lanzi, M.D.</b>		22e. ADDRESS <b>721 Bridge Street, Elkton, Md. 21921</b>		
23a. BURIAL, CREMATION, REMOVAL TYPE <b>Burial</b>		23b. DATE <b>8-25-82</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cherry Hill Methodist Cemetery, Cherry Hill, Md.</b>	
24. MEDICAL DIRECTOR <b>Ralph E. Stiles</b>		ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>	25a. DATE REC'D. BY REGISTRAR <b>AUG 30 1982</b> 25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removals.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 1 1 3 0							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
Austin D. Comblin						August 28, 1982			1:00pm								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN					
Male		White		4 27 03			79										
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
Md.		U.S.A.					Cecil			Elkton							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
Union Hospital										Engineer							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Md.				Cecil		Elkton				376 Frenchtown Rd.							
14. FATHER'S NAME				MIDDLE		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS			
Fred						Mae		147-03-3167				Nina Comblin		Elkton			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
										DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular disease</u>							
										DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> , 19 <u>82</u> , to <u>8/28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Rolando A. Najera</u>										DEGREE M.D.							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando A. Najera, M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
										22e. ADDRESS 105 E. Main St. Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 8/1/82			23c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery			23d. LOCATION CITY OR TOWN Elkton COUNTY Cecil STATE Md.								
24. FUNERAL DIRECTOR NAME See Funeral Home			ADDRESS Elkton Md.			25a. DATE REC'D. BY REGISTRAR SEP 2 1982			25b. REGISTRAR'S SIGNATURE <u>John J. Carroll</u>								

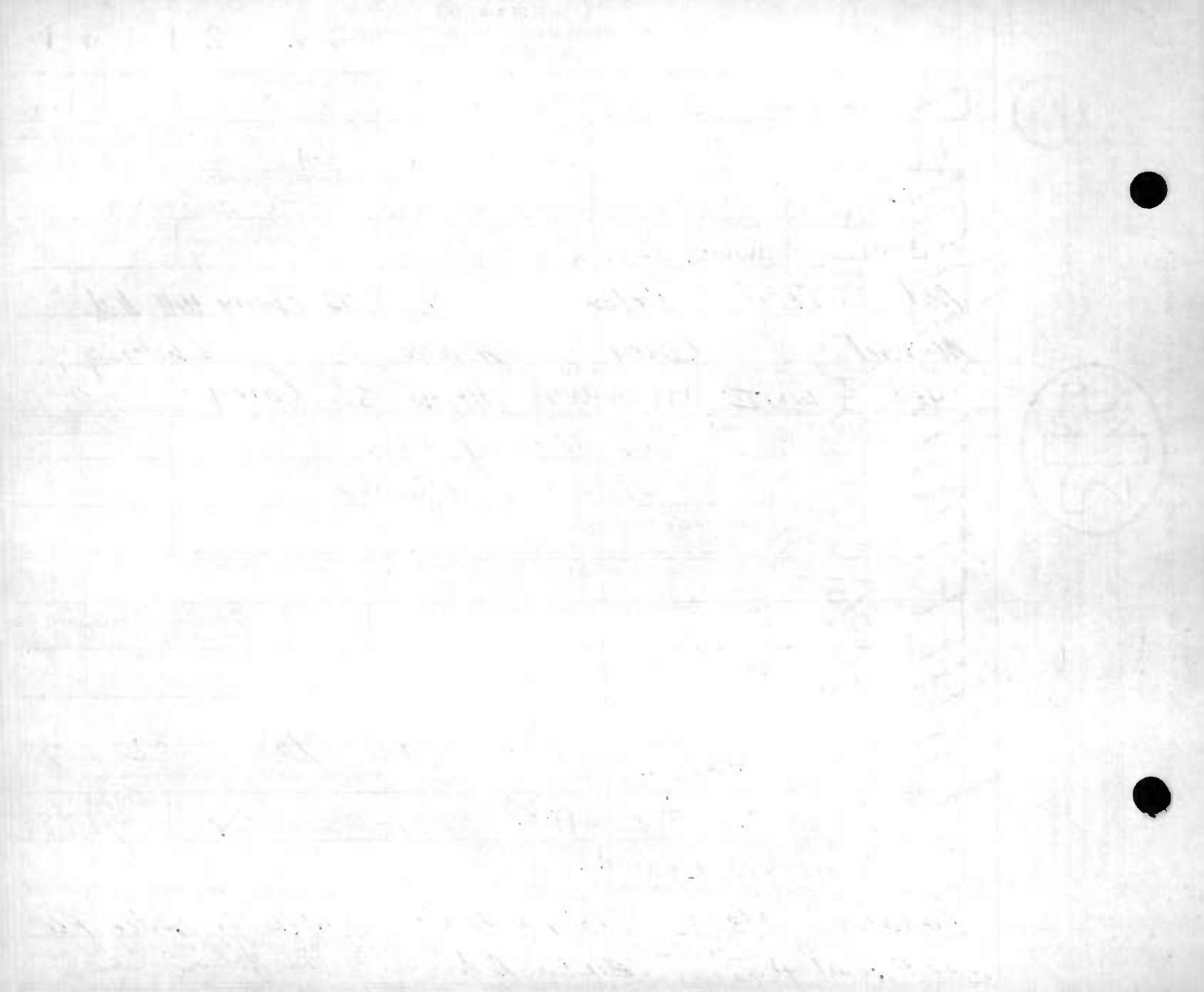


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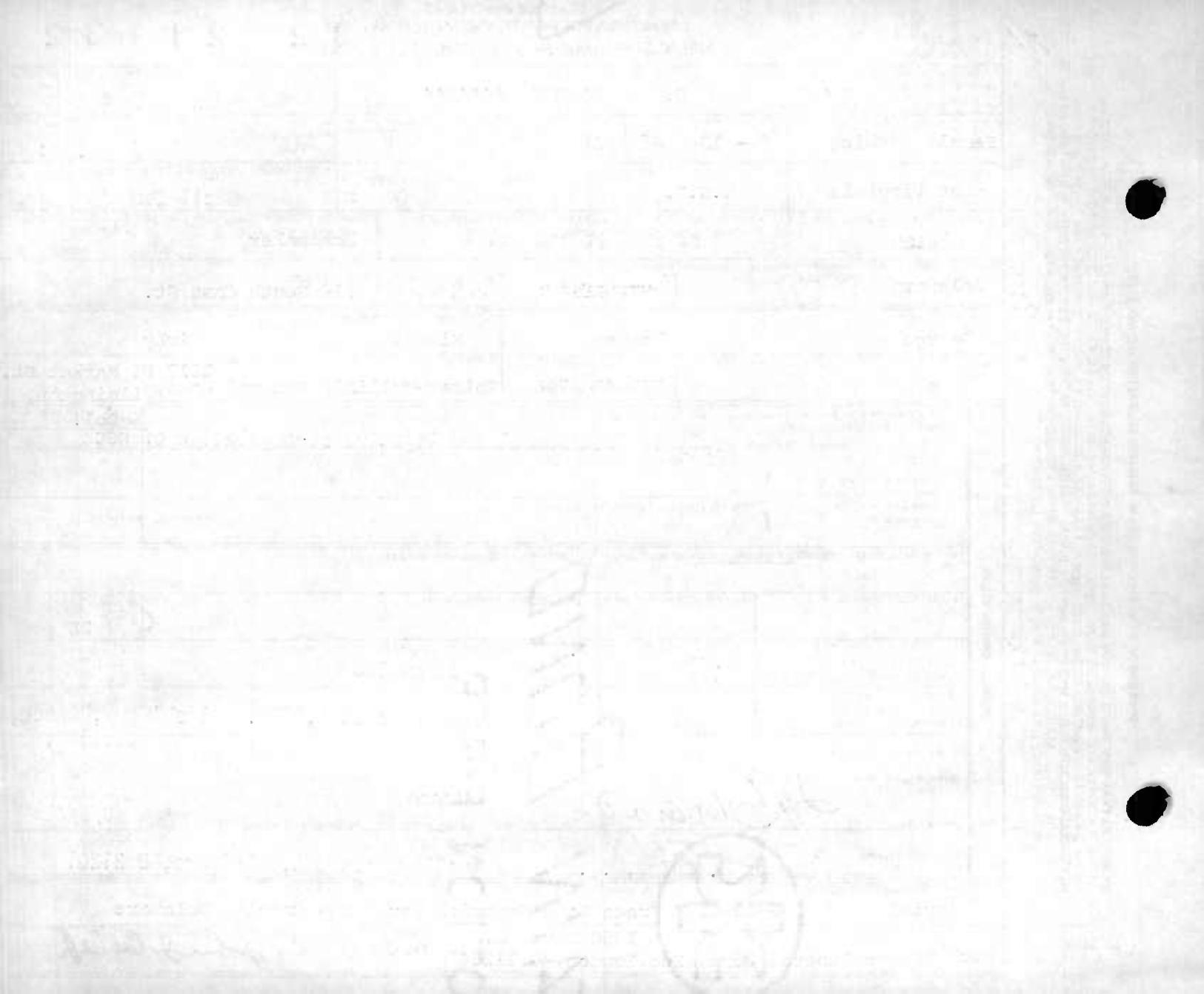
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	2	1	1	3	1
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
William C CAREY						8-28-82						5:40 PM						
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
M			C	MONTH	DAY	YEAR	64			MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH						
PA.			USA.						CECIL COUNTY MD.			ELKTON						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
UNION HOSPITAL OF C.C.																		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Md.			Cecil			Elkton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			72 Cherry Hill Rd.						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
Michael					Carey	Mable					Whitting							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Yes			199-01-0635			Helen S. Carey												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio Pulmonary Arrest</u>																		
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial infarction</u>																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>8/28/82</u> , 19 <u>82</u> , to <u>8/28</u> , 19 <u>82</u> , that (I) <u>we</u> last saw the deceased alive on <u>8/28/82</u> , 19 <u>82</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED									
VINCENT BRANDIS MD												8/28/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
VINC. ENT BRANDIS																		
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN COUNTY STATE									
Cremation			8/30/82			Crown & Ferrells			West Chester Chester Pa									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Gee Funeral Home			Elkton Rd			SEP 2 1982			John J. Conroy									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1-2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21132	
1- FOR STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <b>xx 8 6 1982</b>									2b. HOUR M	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Shirley			MIDDLE D.			LAST CONLEY Thompson				
1. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 - 13 - 45</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>36 yrs.</b>		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b>		10. DATE PRONOUNCED DEAD <b>8 6 1982</b>		11. DATE MONTH DAY YEAR <b>4:00A</b>			
11. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SURGEON FACILITY, GIVE STREET ADDRESS) <b>West End Gardens Motel</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Delaware</b>		13b. COUNTY <b>Middlesex</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>916 South Cass St.</b>							
14. FATHER'S NAME FIRST <b>George</b>		MIDDLE		LAST <b>Thompson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Minnie</b>		MIDDLE		LAST <b>Kirby</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>227-40-6796</b>		17. INFORMANT <b>Spicer-Mullikin Funeral Home, Wilmington,</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9630</b> IMMEDIATE CAUSE <b>Asphyxia from manual and ligature strangulation of neck</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		ADDRESS <b>2317 N. Market St.</b>		APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <b>1981</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. <b>8/6 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>found strangled</b>		21d. LOCATION STREET <b>West End Gardens Motel, 205W. Pulaski Hwy, Elkton, Cecil Co, MD</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <b>xx</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>motel room</b>		21f. LOCATION STREET <b>West End Gardens Motel, 205W. Pulaski Hwy, Elkton, Cecil Co, MD</b>									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) <b>Assistant</b>		22c. M.D. MEDICAL EXAMINER									
ACTUAL SIGNATURE <i>H. Guard</i>										DATE SIGNED <b>8/6/82</b>			
EXAMINER'S NAME (TYPE OR PRINT)		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-12-82</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Grace Lawn Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>New Castle, Delaware</b>		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>									
20M 4/B2													
DHMH - 17 (VR A15 ME (5))													



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Board of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked "Yes" or "No" on this certificate, the medical examiner must be notified.

**IMPORTANT:** If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical history and treatment records must be made available.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 2 1 1 3 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH			YEAR			2b. HOUR					
Norman A. Crockett						8/10/82									1040 M					
3. SEX:		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			70			IF UNDER 1 YEAR							
Male		White		Month Day Year			YRS			70			MONTHS DAYS HOURS MIN.							
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Cecil			MD.							
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Elkton		Union Hospital		Self-employed Carpenter																
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			424 Elk Mills Road											
Maryland		Cecil		Elkton																
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17. INFORMANT			ADDRESS					
FIRST MIDDLE LAST Joseph - Crockett						Louise			No			Mrs. Anna M. Crockett, Elkton, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY:						IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1850						Renal failure			Multiple metastases to Bone, lung, liver											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/04 19 82 to 8/10 19 82, that (I) (we) lost saw the deceased alive on 8/10 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Eddie S. Saw						M.D.												8/13/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS														
Eddie S. Saw, MD						Elkton, Md.												21921		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE							
Burial		8-14-82		New London Presbyterian Cemetery			Cemetery, New London, Pa.													
24. FUNERAL DIRECTOR Ralph E. Hicks						ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
						Hicks' Home for Funerals, Elkton, MD.			AUG 1 1982			John J. Cawley								



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be

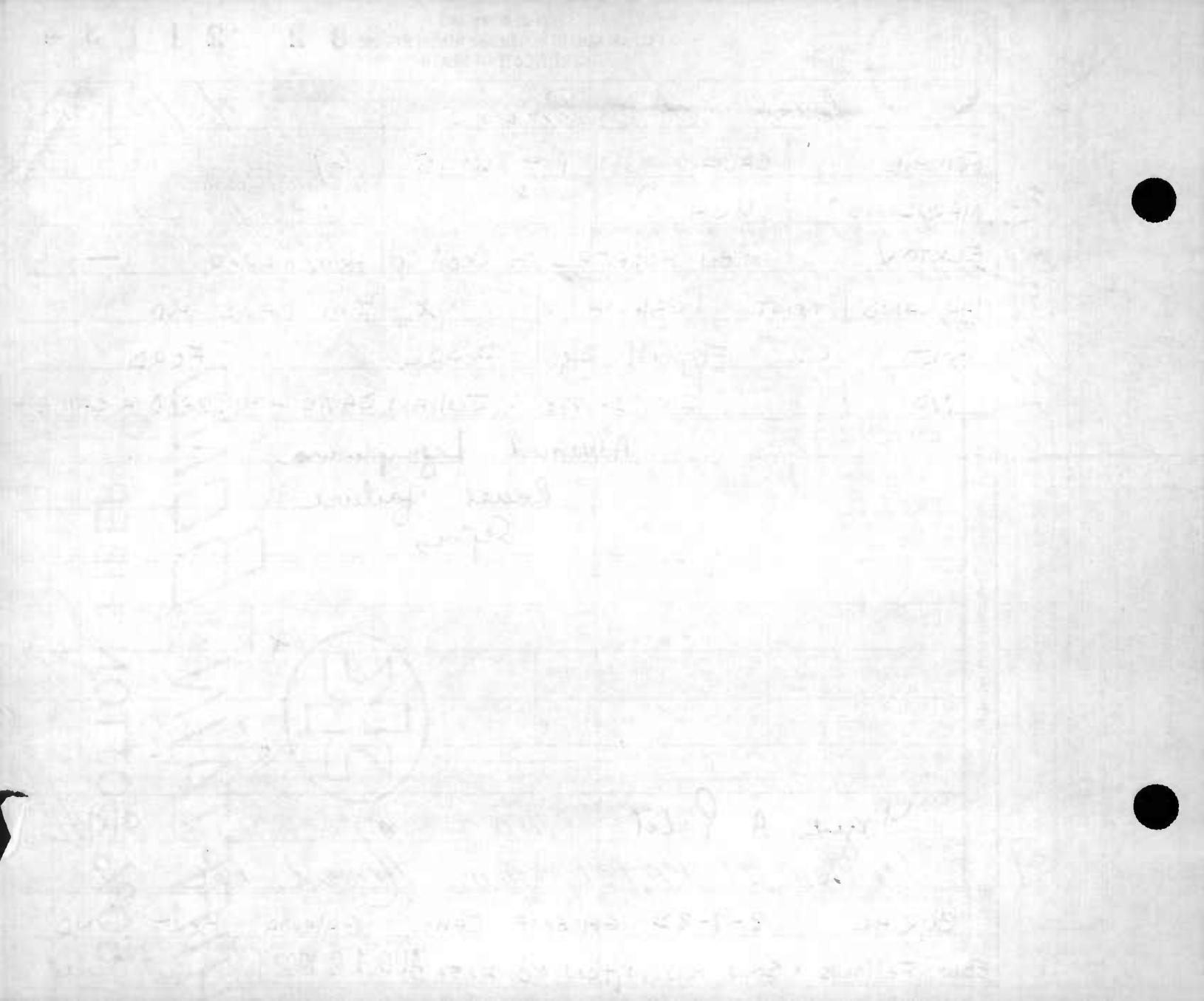
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/master permit. Then please remove carbon paper. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 1 1 3 4
1. FOR STATE REGISTRAR				REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR
Helen F. Davis				8/5/82
3. SEX Female		4. RACE CAUC.		2b. HOUR 3 1/2 P.M.
BIRTHPLACE STATE OR FOREIGN COUNTRIES MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 67
8. IF UNDER 1 YEAR MONTHS DAYS		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co		10. IF UNDER 24 HRS HOURS MIN.
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL of Cecil Co		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker
13a. STATE MARYLAND		13b. COUNTY Kent		12b. KIND OF BUSINESS OR INDUSTRY —
13c. CITY OR TOWN Galena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Jim Davis Rd
14. FATHER'S NAME Robert		15. MOTHER'S MAIDEN NAME Pearl		FORD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-72-1873		17. INFORMANT R. JULIAN DAVIS - HUSBAND - SAME -
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART 1. DEATH WAS CAUSED BY 2028 IMMEDIATE CAUSE (a) Advanced lymphoma				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) (c) DO TO, OR AS A CONSEQUENCE OF Renal failure Sepsis				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Yogish A. Patel		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/5/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish A Patel		22e. ADDRESS no Newark, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-7-82	23c. NAME OF CEMETERY OR CREMATORIAL GALENA Cem.	23d. LOCATION CITY OR TOWN GALENA COUNTY KENT STATE MD
24. FUNERAL DIRECTOR NAME Edw. Fellows + Son MILLINGTON MD 21651		25a. DATE REC'D. BY REGISTRAR AUG 12 1982		25b. REGISTRAR'S SIGNATURE John J. Carroll
ADDRESS VRA 15, 4)				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death  
 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 2 1 1 3 5

1. DECEASED NAME (TYPE OR PRINT)	FIRST <b>Marion</b>	MIDDLE <b>Thaddeus / DESKIEWICZ</b>	LAST	2a. DATE OF DEATH MONTH <b>August</b>	DAY <b>21</b>	YEAR <b>1982</b>	2b. HOUR <b>9:55 A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>2</b>	DAY <b>8</b>	YEAR <b>1908</b>	6. AGE (IN YEARS LAST BIRTHDAY) 7b. YRS <b>74</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>	MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Military/Retired</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>124 South Parke Street</b>			
14. FATHER'S NAME FIRST <b>John</b>	MIDDLE <b>Deskiewicz</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Hedwig</b>	MIDDLE	LAST <b>Deskiewicz</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>1933-1960</b>	17. INFORMANT <b>Vera E. Deskiewicz, 124 S. Parke St., Aberdeen,</b>	Md. 21001				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: <b>1889</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Paraneoplastic Effect of Metastasis</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ca of Bladder</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Maturity Onset Diabetes Mellitus Recurrent Renal Infections</b>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>8/21</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I did not) view the body after death.	22b. SIGNATURE <b>Glendon E. Rayson</b>				DEGREE	22c. DATE SIGNED <b>8/21/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Glendon E. Rayson</b>	MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL <b>VA Medical Center Perry Point, Md.</b>			23d. LOCATION CITY OR TOWN	COUNTY	STATE
24. FUNERAL DIRECTOR NAME <b>TARRING FUNERAL HOME, P.A., Aberdeen, Md.</b>	ADDRESS <b>21001-3399</b>	25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1982</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Conigli</b>		

22-9  
1000 ft down

1500 ft down

1500 ft down

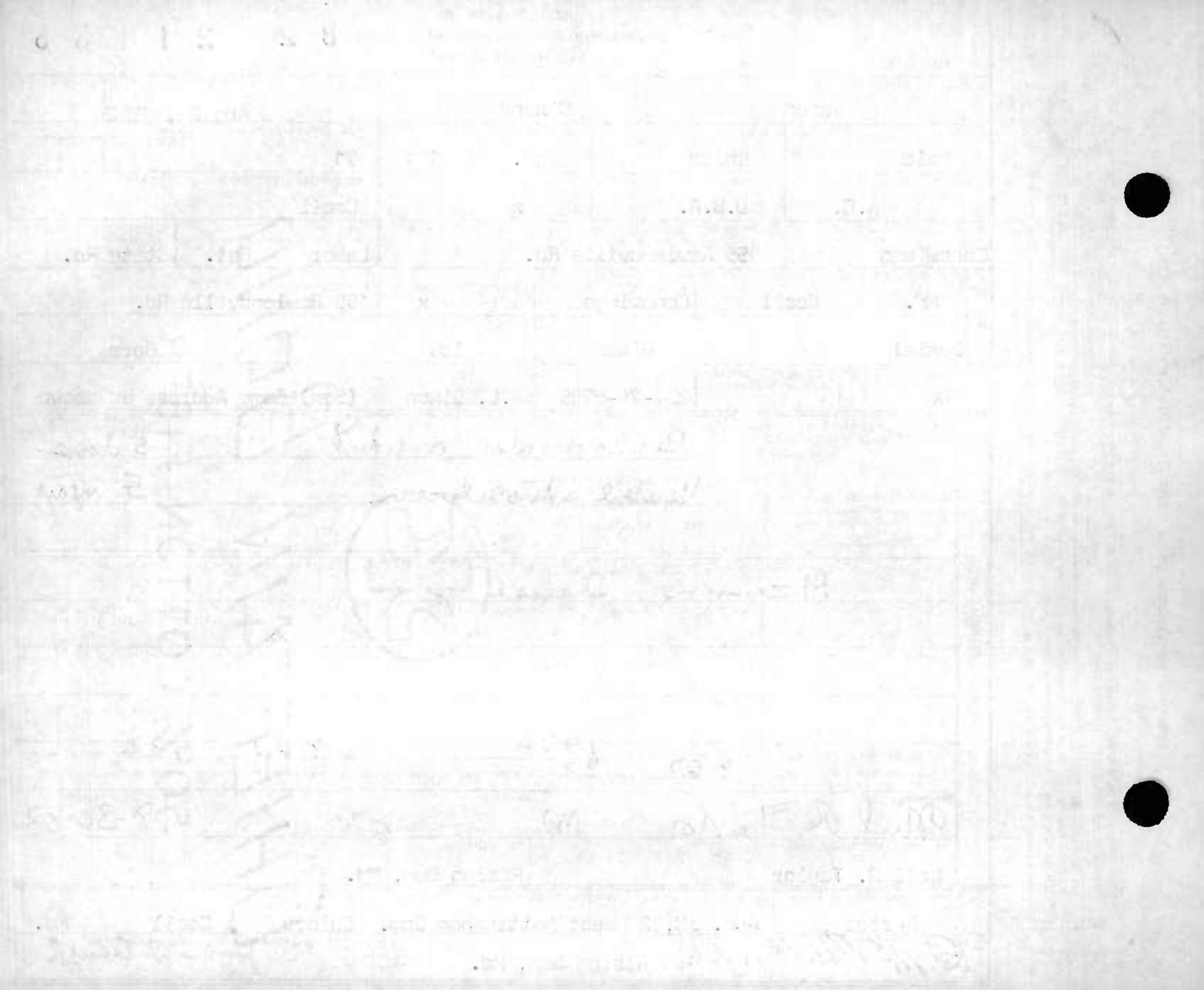
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

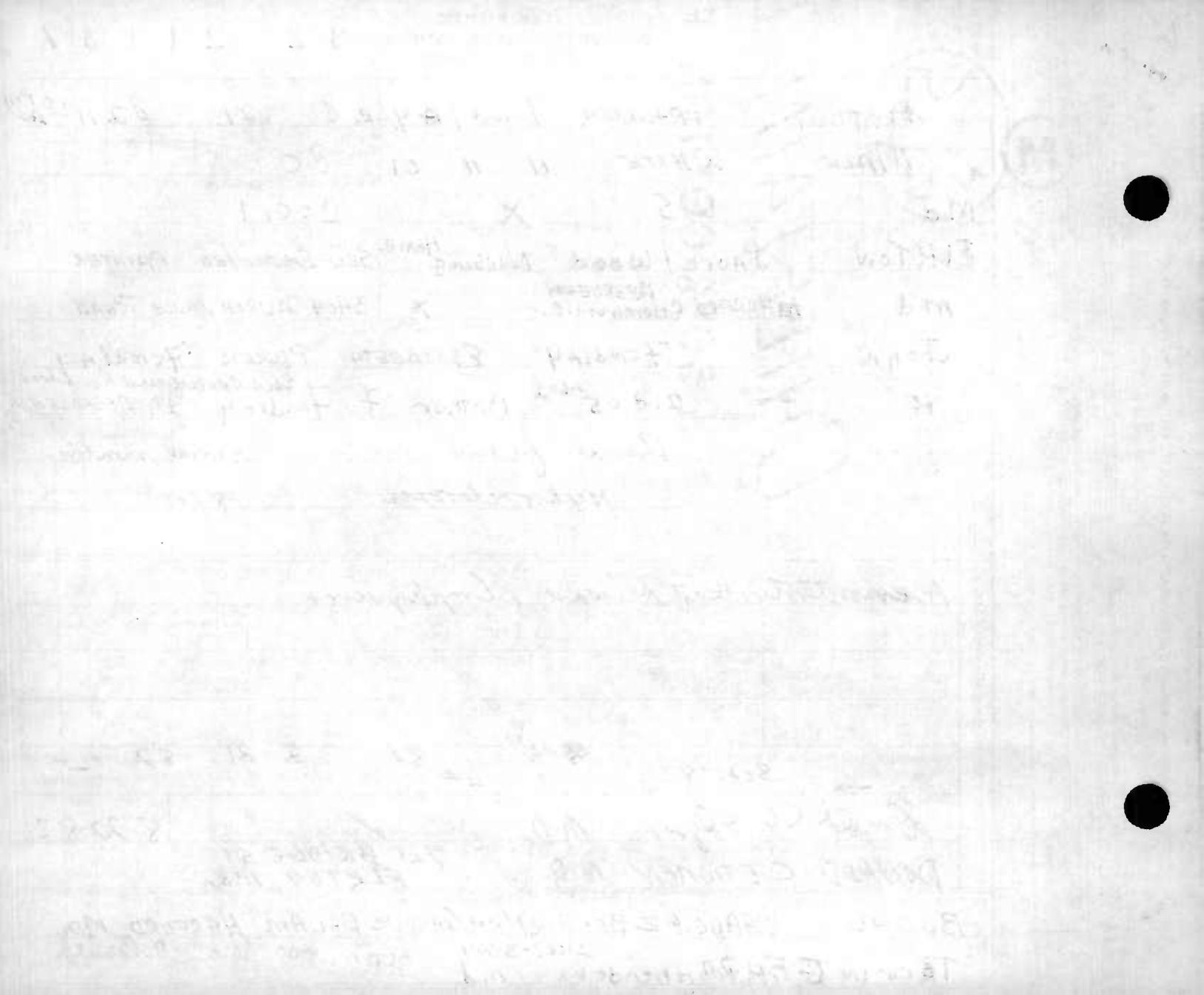
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial/transit permit. Then please remove carbonpaperrs. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	2	1	1	3	6			
												REG. NO.									
1 - STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
		Namon			Dixon			Aug 27, 1982													
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS								
Male		White			Sept. 16 1910			71			MONTHS	DAYS	HOURS	MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH													
N.C.		U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Conowingo		195 Rowlandville Rd.			Labor Ret.			State Rd.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.		Cecil		Conowingo		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		195 Rowlandville Rd.													
14. FATHER'S NAME		MIDDLE LAST			15. MOTHER'S MAIDEN NAME																
Daniel		Dixon			Ida																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS														
No		237-24-8789			R.L. Dixon (Son)		Same Address as above														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360												5 days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost { DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>												5 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Alzheimer's Disease</u>																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																
22a. I certify that (I) (this hospital) attended the deceased from 1976, 19____, to 8-27, 1982, that (I) (we) last saw the deceased alive on 8-25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>Neil R. Taylor</u>		MD			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-30-82											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Neil R. Taylor			22e. ADDRESS		Rising Sun, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		Aug. 30, 82			West Nottingham Cem. Rising Sun, Md.			Colora Cecil Md.													
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE																
John Mullin Jr.					SEP 1 1982			John L. Lough													







RECORDED IN HOSPITAL OR ATTENDING PHYSICIAN. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PAGE 4 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Department of Health, and Manual of Funeral Practice, or removal.

**IMPORTANT:** If item 21 is marked or from 18 choose ANY variety, or *Salvia nemorosa* (wood sage) choose more than one.

MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 1 3 8

1. DECEASED NAME (TYPE OR PRINT) <b>William B. Founds</b>			2a. DATE OF DEATH MONTH <b>8 14 82</b>	2b. HOUR <b>9:30 p.m.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>6 2 1892</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>	IF UNDER 24 HRS. HOURS MIN.
10. CITY OR TOWN OF DEATH <b>Rising Sun</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO. IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Calvert Manor Nursing Home</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Signal Dept. B. &amp; O. Railroad</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>O. Railroad</b>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Cecil</b> 13c. CITY OR TOWN <b>Peccyville</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>Broad St.</b>				
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Wesley</b> LAST <b>Founds</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Hannah</b> MIDDLE <b>Murphy</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>905-07-4959</b>	17. INFORMANT <b>G. Wesley Founds, Rising Sun, Md. 21911</b>	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY  IMMEDIATE CAUSE (a) <b>2500</b> <i>Myocardial disease</i>  DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i>  DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>10/29</b> , 19 <b>74</b> , to <b>8/14</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8/14</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>James R. Dearwold, M.D.</b>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>8/18/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Dearwold, M.D.</b>	22e. ADDRESS <b>167 W. Main St. Newark Del. 19711</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-17-82</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cherry Hill Methodist Cemetery, Cherry Hill, Md.</b>	23d. LOCATION CITY OR TOWN	COUNTY STATE
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>	ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>	25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1982</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, then medical certification is required.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					82	21	139	
					REG. NO.			
1. FOR STATE REGISTRAR	FIRST ROBERT	MIDDLE LOUIS	LAST GAINES	2a. DATE OF DEATH August 18, 1982	MONTH AUG	DAY 18	YEAR 1982	2b. HOUR 6:30 am
3. SEX m.	4. RACE Black	5. DATE OF BIRTH MONTH 10 DAY 27 YEAR 34	6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.	IF UNDER 1 YEAR MONTHS 0			IF UNDER 24 HRS. HOURS 0	
7a. BIRTHPLACE COUNTRY Va	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Perry Point Cecil Co MD					
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawn.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md	13c. COUNTY Ballo	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 100 N. Pulaski St					
14. FATHER'S NAME FIRST Webster	MIDDLE	LAST Gaines	15. MOTHER'S MAIDEN NAME FIRST Mary	MIDDLE Estelle	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. 4100 229-40-3143	17. INFORMANT Bosie	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF Acute Myocardial Infarction Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease Arteriosclerotic cardio vascular disease (c)		ADDRESS 5207 Tabernacle Frederick Rd			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. 19 P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE		
22a. I certify that (this hospital) attended the deceased from June 9, 1982, to August 18, 1982. XXXXXXXXX XXXXXX (above, (I) (we) (we) did not view the body after death) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated								
22b. SIGNATURE Milton Ginsberg, M.D.	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED Aug 20, 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Milton Ginsberg, M.D.	22e. ADDRESS VA Medical Center, Perry Point, Md.							
23a. HOSPITAL, CREMATION, REMOVAL (SPECIFY) 13	23b. DATE 8/24/82	23c. NAME OF CEMETERY OR CREMATORIAL Crown Hill V.A.	23d. LOCATION CITY OR TOWN Crown Hill	23e. COUNTY Md	25a. DATE REC'D. BY REGISTRAR AUG 24 1982			
24. FUNERAL DIRECTOR NAME Joseph L. Russ	ADDRESS 2222 W. youth ave	25b. REGISTRAR'S SIGNATURE John J. Conroy						
25c. DATE REC'D. BY REGISTRAR AUG 24 1982								

Howard - A. V. Howard 5/11/88 61  
nothing was found - types of

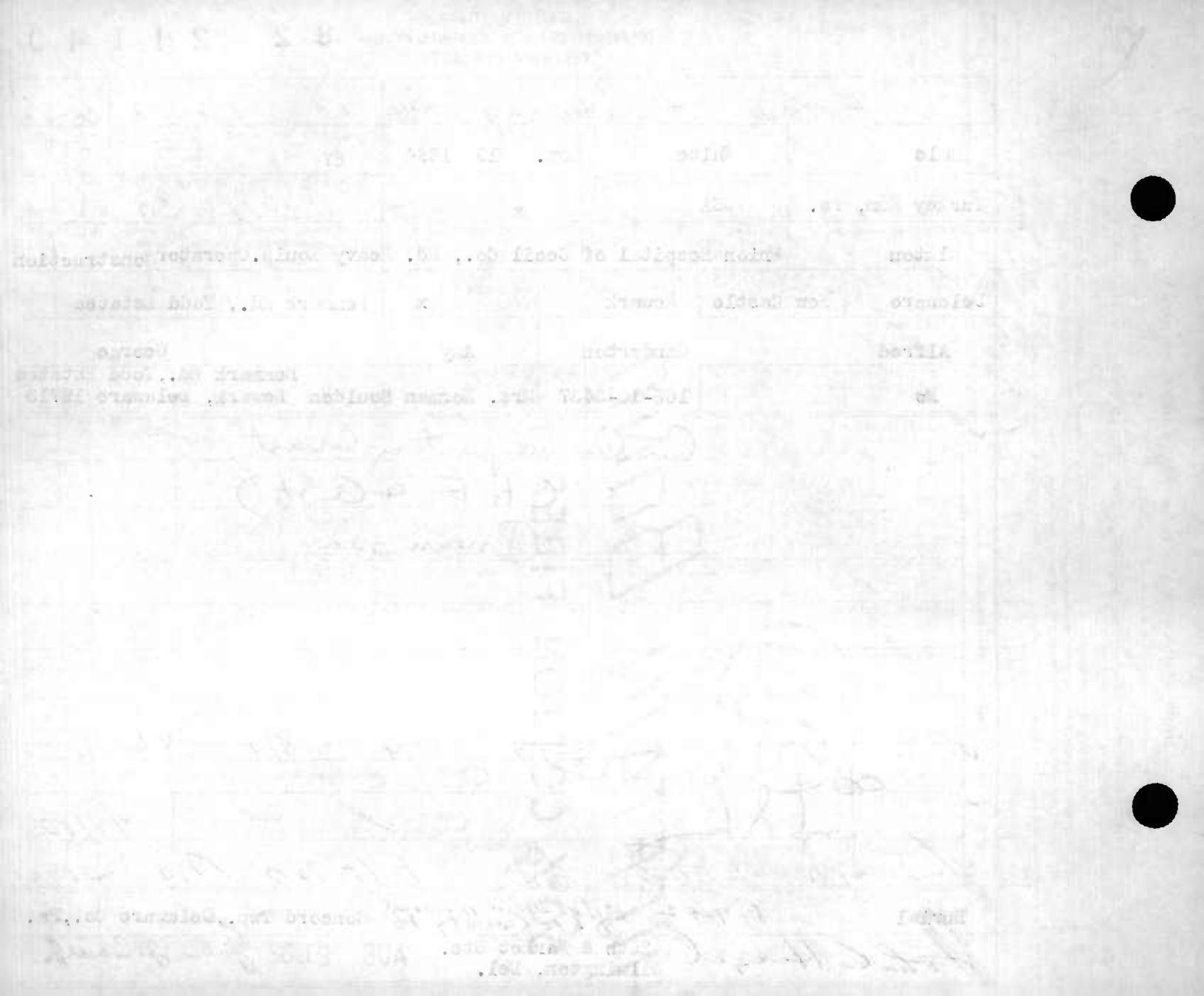
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only be.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82	21140		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Arthur A Ganderton Sr						8/4/82			1240 P M				
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b. HOUR IF UNDER 24 HRS MONTHS HOURS MIN.	
						Nov. 19 1894			87				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey Run, Pa.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.				
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co., Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heavy Equip. Operator Construction			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Delaware			13c. COUNTY New Castle			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Kenmark Rd., Todd Estates				
14. FATHER'S NAME FIRST MIDDLE LAST Alfred			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy George										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 165-10-8437			17. INFORMANT Mrs. Norman Boulden Newark, Delaware 19713			Kenmark Rd., Todd Estates				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY 4860 IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY 4860 IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY 4860 IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			CHF + ASHD							
			(c)			Pneumonia							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3-13-1979 to 8/4/82, that in my (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 8/4/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not witness the body after death.													
22b. SIGNATURE John C. Hinsel			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/4/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Landi MD			22e. ADDRESS Elkton Md 21921										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-7-82			23c. NAME OF CEMETERY OR CREMATORIAL Edgewood Memorial Edgewood County Pa			23d. LOCATION Concord Twp., Delaware Co., Pa.				
24. FUNERAL DIRECTOR NAME John C. Hinsel			25th & Market Sts. Wilmington, Del.			25a. DATE REC'D. BY REGISTRAR AUG 9 1982			25b. REGISTRAR'S SIGNATURE John C. Hinsel				
DHMH - 1650M 1/81 (VRA 15, 4)													



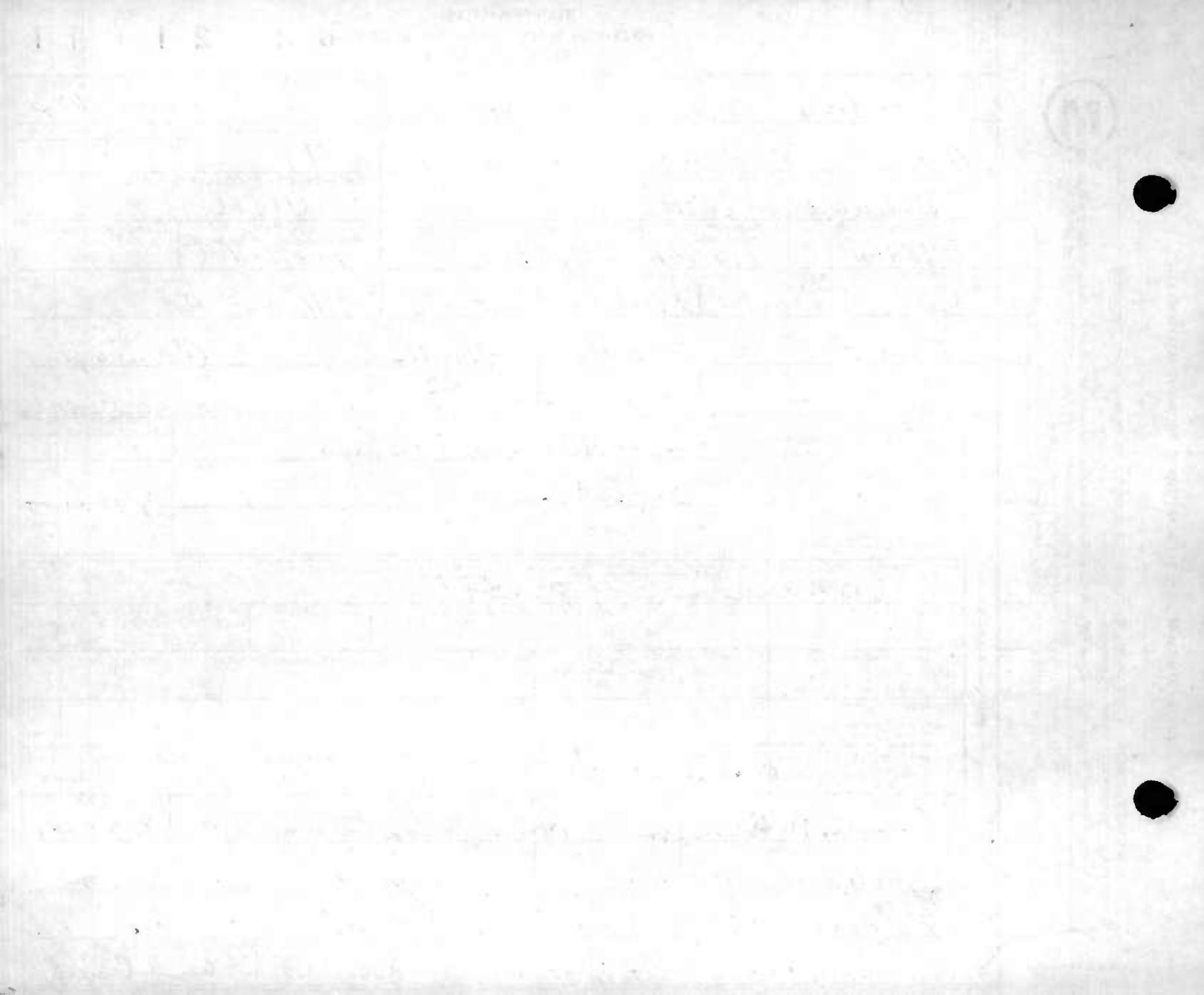
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	2	1	1	4										
										REG. NO.															
1. FOR STATE REGISTRAR		2. DATE OF DEATH										MONTH	DAY	YEAR	2b. HOUR										
		3. DECEASED NAME										4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
		Andrew (W) Grinnage										Black		MONTH	DAY	YEAR	71			MONTHS		DAYS		HOURS	
		7a. BIRTHPLACE		COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH						
		Delaware		USA				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Cecil			Elkton						
		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS														
		MD		Cecil		North East		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			17 Thomas Ave.														
		14. FATHER'S NAME		LAST		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
		Ernest		Webster		Amelia		17818-5896			Fannie Alter			Same as above				4029 Hypertension							
		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. ADDRESS		17. DUE TO, OR AS A CONSEQUENCE OF (b)		18. DUE TO, OR AS A CONSEQUENCE OF (c)		19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		19. MEDICAL CERTIFICATION											
		NO		-				Hypertension				Incarceration of prostate													
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
						<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO																	
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE													
		22a. I certify that (I) (this hospital) attended the deceased from July 1, 1979, to August 28, 1982, that (I) (we) last saw the deceased alive on August 25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE Charles M. Hensgen		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/82															
		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 3 Mouldin Ave. North East, MD.																					
		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/82		23c. NAME OF CEMETERY OR CREMATORIAL ST. MT. CARMEL		23d. LOCATION CITY OR TOWN North East		COUNTY Cecil		STATE MD.													
		24. FUNERAL DIRECTOR NAME Arnold C. Beyer		ADDRESS 353 Fountain St. Hdg. MD.		25a. DATE REC'D. BY REGISTRAR AUG 31 1982		25b. REGISTRAR'S SIGNATURE John J. Cawley																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached to use as the burial-tran permit. Then please remove carbon prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82	21142				
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			MAURICE LOUIS GUIBERSON			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
3. SEX Male			4. RACE White			5. DATE OF BIRTH Jan. 28, 1907			6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil			MD.			
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Railroad						
13a. STATE Md.			13b. COUNTY Cecil			13c. CITY OR TOWN North East			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 623 Mechanics Valley Rd.				
14. FATHER'S NAME FIRST Deleplaine			MIDDLE Guiberson			15. MOTHER'S MAIDEN NAME FIRST Clara			MIDDLE Kline			LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 705-10-0838			17. INFORMANT Lucy P. Guiberson			ADDRESS North East, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b1, and 1c1) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>															
4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____									
22a. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1979</u> to <u>August 15, 1982</u> , that (I) (we) last saw the deceased alive on <u>August 15, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Charles Hensgen</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/17/82						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Hensgen			22f. ADDRESS 3 Mauldin Ave. North East, Md.												
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 8-19-82			23c. NAME OF CEMETERY OR CREMATORIAL Union			23d. LOCATION CITY OR TOWN Elkton			COUNTY Cecil			STATE Md.
24. FUNERAL DIRECTOR NAME <u>Paul O. Finch</u>			ADDRESS North East, Md.			25a. DATE REC'D. BY REGISTRAR AUG 19 1982			25b. REGISTRATION SIGNATURE <u>John J. Cawley</u>						

Letter 2

new Forest, Hampshire

20/10/1913

Autumn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 2 1 1 4 3		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Grace F. Hensel						8 7 82						1:15 PM		
SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White	08 06 06			76			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Cecil Co. MD.		
Elkton, Md.			USA											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton			Laurelwood Nursing Center			Housewife								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md.			Cecil		Elkton					Rt 4, Box 178, Elkton, Md.				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Howard			-		McFadden				Frances	Wilson	Castelow			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			213-05-3986			Frances Wilson Rt 4, Box 178, Elkton, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4292 IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.														
(b) <u>CREMATION</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOVENOUS CHRONIC CHRONIC RENAL FAILURE</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7-31 1982 to 8-1-24 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Rolando A. Najera</u> DEGREE														
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Rolando A. Najera, M.D.			105 E. Main Street, Elkton, Md. 21921											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE
Burial			8-10-82			Cherry Hill Methodist			Cemetery, Cherry Hill, Md.					
24. FUNERAL DIRECTOR <u>Robert E. Hicks</u>			ADDRESS						25a. DATE RECEIVED BY REGISTRAR OR REC'D. REC'D. SIGNATURE					
Hicks Home for FUNERALS, ELKTON, MD.									AUG 15 1982 <u>John H. Smith</u>					

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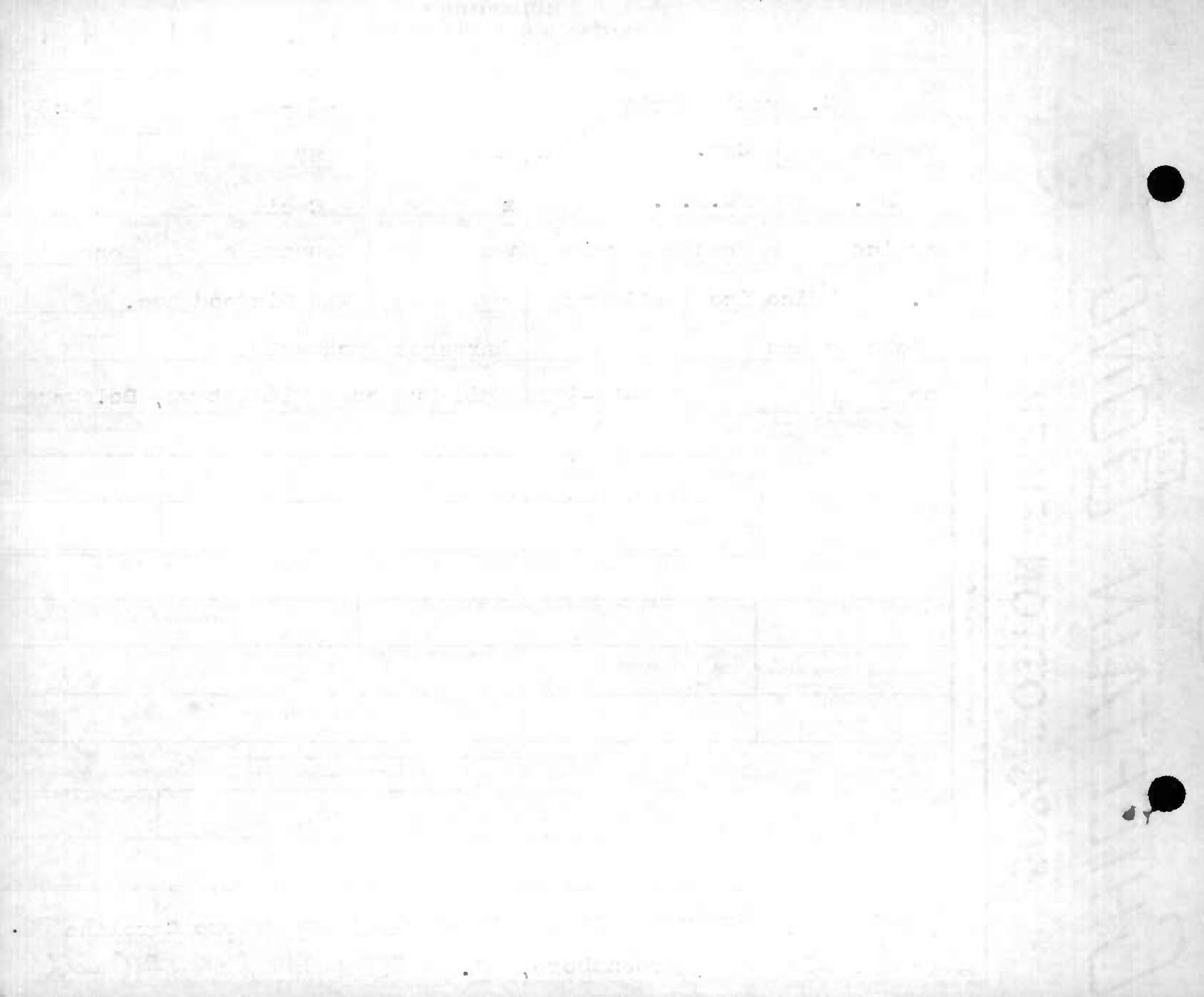
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the death of a patient retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPROVEMENTS IN THE PRODUCTION OF COTTON IN THE UNITED STATES, 1860-1910

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1 - FOR STATE REGISTRAR											3 2 2 1 1 4 4			
REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
E. Mystle Hurley						8-25-82						10:30 A		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Cau.		1-10-02			80			YRS	MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.		U.S.A.					Cecil							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Warwick		Graham Nursing Home			Housewife			None						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Md.	Wicomico	Salisbury				215 Linwood Ave.								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
John Hughes			Margaret Buckmaster											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS							
no		214-10-6026		Emil Hughes			Middletown, Delaware							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:														
7070 IMMEDIATE CAUSE (a) <u>Spas</u>														
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>duerhers ulcra</u>														
DOUE TO, OR AS A CONSEQUENCE OF (c) <u></u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> , 19 <u>82</u> , to <u>8-25</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7-32</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Bennett T. Hurley, MD</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE 8-28-82		23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery			23d. LOCATION CITY OR TOWN Greensboro		COUNTY	STATE Caroline				
24. FUNERAL DIRECTOR NAME <u>John J. Conigli</u>		ADDRESS Greensboro, Md.			25a. DATE REC'D. BY REGISTRAR SEP 2 1982			25b. REGISTRAR'S SIGNATURE <u>John J. Conigli</u>						

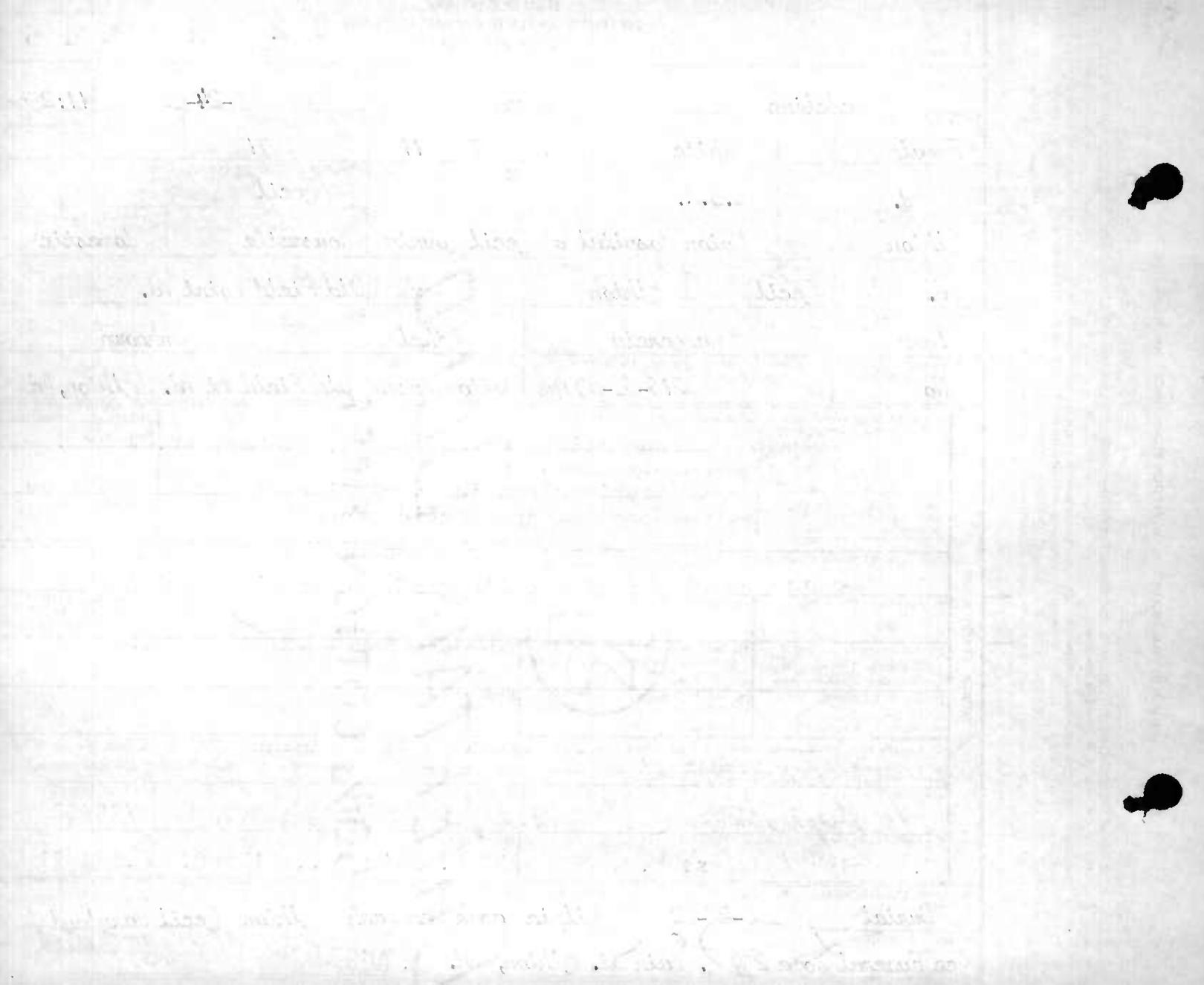


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2	2 1 1 4 5					
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Madeline									Jensen			8-24-82					11:25pm	
1. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 MRS					
Female		White			2 7 11			71 YRS.			MONTHS		DAYS		HOURS			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			<input checked="" type="checkbox"/>		<input type="checkbox"/>		DIVORCED		<input type="checkbox"/>	
Md.		U.S.A.			MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			<input checked="" type="checkbox"/>		<input type="checkbox"/>		DIVORCED <input type="checkbox"/>		<input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.							
Elkton		Union Hospital of Cecil County			Housewife			domestic										
13a. STATE		13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>		14. STREET ADDRESS			
Md.		Cecil			Elkton			INSIDE CITY LIMITS?			<input type="checkbox"/>		<input checked="" type="checkbox"/>		Old Field Point Rd.			
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME		MIDDLE			LAST		
Tony								Ethel								Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		216-66-6309m			Otto Jensen			Old Field Pt Rd. Elkton, Md.			24 hrs.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:																		
IMMEDIATE CAUSE (a) <u>4140</u> Congestive heart failure, acute, sv												24 hrs.						
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease												over 1 yr.						
DUE TO, OR AS A CONSEQUENCE OF and aortic stenosis (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
29		Probable carcinoma of the liver of undetermined origin																
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
							<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>August 2, 1976</u> to <u>August 24, 1982</u> , that (I) (we) lost saw the deceased alive on <u>August 24, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Ralph Andrews</u>		DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			22c. DATE SIGNED <u>8/25/82</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Ralph Andrews, M.D.		22e. ADDRESS 233 E. Main St., Elkton, Md. 21921																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-82			23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Mem Park			23d. LOCATION CITY OR TOWN Elkton			COUNTY		STATE					
24. FUNERAL DIRECTOR Gee Funeral Home 259 E. Main St. Elkton, Md.								25a. DATE REC'D. BY REGISTRAR AUG 30 1982			25b. REGISTRAR'S SIGNATURE <u>John G. Coughlin</u>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 3, AND 2 SHOULD BE FILED, WITHIN 72 HOURS, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 1200 PINE ST., BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BALTIMORE, MARYLAND 21201

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 2 1 1 4 6							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED			2b. HOUR MONTH DAY YEAR				
Joseph			U			Jones						<input checked="" type="checkbox"/> 8 23 1982							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR MONTH DAY YEAR		
Male		W		4 29 51			31 yrs.			MONTHS		DAYS		HOURS		11:15P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH										
Delaware			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Civil County MD										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b. KIND OF BUSINESS OR INDUSTRY										
Earleville			At 982 et Archway Inn			Delaware New Castle Townsend			Chrysler Ops. motors										
13a. STATE COUNTY			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Main St										
14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME																
Miles E. Jones Sr.			Mabel Conley																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT													
No			221-38-8397			miles P. Jones Jr. Townsend, Ad													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY: 8159																			
IMMEDIATE CAUSE (a) Massive head trauma																			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																			
(b) Motorcycle accident																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?													
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)													
8 23 1982						Subject was thrown of motorcycle that crashed													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION													
Road						Streets At 982			CITY OR TOWN Earleville		COUNTY Cecil		STATE MD						
22a. I certify that I took charge of the remains described above, held an												TITLE (SPECIFY)							
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												M.D. Deputy, MEDICAL EXAMINER							
ACTUAL SIGNATURE <u>Juan C. Gonzalez-Vitale</u>												DATE SIGNED 8/23/82							
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS																
Juan C. Gonzalez-Vitale, MD			Union Hospital, Elkhon, MD 21901																
23a. BURIAL/CREMATION/REMOVAL SPECIES			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY Cecil			23f. STATE MD				
Burial			8/27/82			Townsend Cem.			Townsend			Cecil			MD				
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Robert C. Hutchinson - Millerton Ad						AUG 30 1982			John J. Conroy										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	2	1	1	4	
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
JAMES			F.		JUDD, JR.	August 29, 1982						p.m.				
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White		MONTH April DAY 26, YEAR 1929		53			MONTHS	YEARS	MONTHS	YEARS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland			USA				Cecil			MD						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Elkton			105 Friendship Road							Finance Dept.			U.S. Govt.			
13a. PRELIMINARY RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland			Cecil		Elkton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			105 Friendship Road						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
			James	F.	Judd, Sr.				Edna	M.	Stewart					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
Yes			1951-57		218-22-9495			Mrs. Audrey A. Russell, Elkton, Md. 21921								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF pulmonary disease with bulloous emphysema and bronchitis { DUE TO, OR AS A CONSEQUENCE OF (c)										over 1 yr.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (we) attended the deceased from May 20, 1976, to August 29, 1982, that (I) (we) last saw the deceased alive on July 20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE S. Ralph Andrews, M.D.										DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/1/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Ralph Andrews, M.D.										22e. ADDRESS 233 E. Main St., Elkton, Md. 21921						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-2-82		23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Memorial			23d. LOCATION CITY OR TOWN Park, Elkton, Maryland			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME HICKS HOME for FUNERALS, ELKTON, MD.			ADDRESS					25a. DATE REC'D. BY REGISTRAR SEP 9 1982			25b. REGISTRAR'S SIGNATURE John O. C. . .					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 18c 21-22a  
FOR STATE Film 571 9-23-82 cn  
REGISTRAR

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 21148

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Audrey M. Lewis						8/19/82			1225 M		
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2-22-11		6. AGE (IN YEARS LAST BIRTHDAY) 71 yrs.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7b. BIRTHPLACE 75 Penn.		7b. CITIZEN OF WHAT COUNTRY? HSA.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co.					
10. CITY OR TOWN OF DEATH Dover		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Towson Hospital		12. USUAL OCCUPATION Housewife		13. KIND OF BUSINESS OR INDUSTRY					
13. STATE Delaware		14. COUNTY N.C.		15. CITY OR TOWN Towson		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. STREET ADDRESS Rural			
18. FATHER'S NAME — — —		19. MOTHER'S MAIDEN NAME Nellie - wife		20. ADDRESS Robert Lewis Crettinge Belif							
18a. WAS DECLARED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		18b. SOCIAL SECURITY NO. 221-76-5671		18c. INFORMANT							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960		DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure		DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Lung Disease, Ex Nip.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Electrolyte Imbalance- Corrected, Hypertension.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY 5:30 A.M. MONTH P.M. 8 16 YEAR 1982		21c. HOW INJURY OCCURRED Lost her balance and fell		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET Rt. 1, Box 14, Townsend, Del.		CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE John Smoluk, M.D.		22c. DEGREE		22d. DATE SIGNED 25 Aug 82					
22e. PHYSICIAN'S NAME (IN PENCIL) John Smoluk		22f. ADDRESS Elton Maryland									
23a. BURIAL, CREMATION, REMOVAL cremation		23b. DATE 8/24/82		23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook		23d. LOCATION 1101 University N.C. Rd.					
24. FUNERAL DIRECTOR Robert C. Schleifer - Middlestand				25a. DATE READ BY REGISTRAR Aug 25 1982		25b. REGISTRAR'S SIGNATURE Janet C. Conroy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (Pages 3 should be detached for use as the Burial-Transit Permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, an immediate cause of death should be checked.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 1 1 4 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Mabel</i>			<i>K. Lied</i>			<i>8 24 1982</i>				<i>7:30 A M</i>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
Female		White		November 17, 1901			80 yrs. yrs.			IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH MD.							
Pennsylvania		USA		Cecilton							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Elkton		Union Hospital		LPN			Nursing				
13a. STATE Penn.		13b. COUNTY Delaware		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 938 Lincoln Avenue				
14. FATHER'S NAME FIRST Jared		MIDDLE -		15. MOTHER'S MAIDEN NAME FIRST Bertha			LAST Moore				
LAST Kerns											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No		197-18-1157		Mrs. Dorothea L. West, Chesapeake City, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <i>Cardiorespiratory Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Carcinoma of Lung,</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) <i>(his/hospital)</i> attended the deceased from 7/18 1982 to 8/24 1982, and that (I) (we) lost saw the deceased alive on 8/23 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jo Ann Rosenfeld</i>		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-24-82</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jo Ann Rosenfeld MD</i>		22e. ADDRESS <i>Cecilton, Md</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-26-82		23c. NAME OF CEMETERY OR CREMATORIAL Fernwood Cemetery			23d. LOCATION CITY OR TOWN Lansdowne		COUNTY	STATE	
24. FUNERAL DIRECTOR HICKS		ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.			25a. DATE REC'D. BY REGISTRAR AUG 30 1982		REGISTRAR'S SIGNATURE <i>Jo Ann Rosenfeld</i>				



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT RETAIN PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201, PHR 30, BURIAL CREMATION, OR REBURIAL.

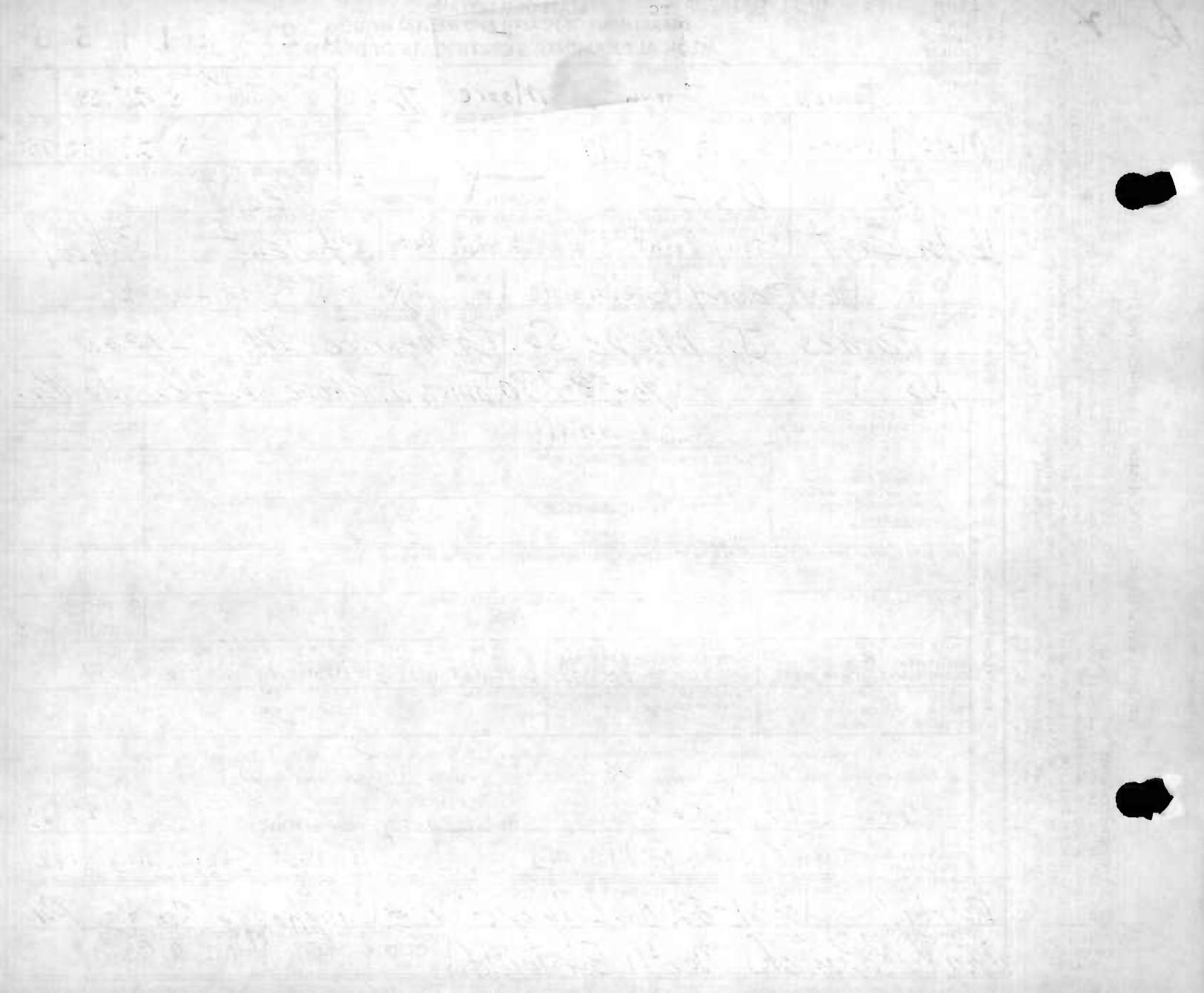
MEDICAL CERTIFICATION

Item #0 Film G571 9/14/82 rc STATE OF MARYLAND  
1- FOR STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH 82 2 2 1 1 5 0  
REC. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST James	MIDDLE Joseph	LAST Moore Jr.	REG. NO.	
2. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9. DATE KNOWN OF ESTI- DEATH MATED MONTH DAY YEAR	10. HOURS MONTH DAY YEAR
Male	White	8 14 65	17			8 25, 1982	2b. HOURS 7:30 AM
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		12. CITIZEN OF WHAT COUNTRY?			13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	14. BALTIMORE CITY OR COUNTY OF DEATH Peclet	
Pa		USA				15. BALTIMORE CITY OR COUNTY OF DEATH School	
16. CITY OR TOWN OF DEATH North East		17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stony Point, Elk Neck State Park			18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		19. KIND OF BUSINESS OR INDUSTRY School
19a. STATE PA		19b. COUNTY Montgomery		19c. CITY OR TOWN Glenside	19d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19e. STREET ADDRESS 391 Tyson Avenue	MD
20. FATHER'S NAME FIRST James J. Moore Sr.		MIDDLE	LAST	21. MOTHER'S MAIDEN NAME Catherine M. Logan		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		24. SOCIAL SECURITY NO. 170-58-7730			25. INFORMANT James J. Moore Sr. Glenside Pa.	26. ADDRESS	
27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9102 IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying</u> cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
28a. DATE OF OPERATION		28b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					28c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
29a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		29b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8 25 1982		29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was swimming in Elk River			
30a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		30c. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
31a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Deputy</u> TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vitali, MD M.D. MEDICAL EXAMINER ADDRESS Union Hospital, Elkton, MD 21921 DATE SIGNED 8/27/82							
32a. BURIAL, CREMATION, REMOVAL HOSPITAL		32b. DATE 8-31-82		32c. NAME OF CEMETERY OR CREMATORIAL Our Lady of Grace		32d. LOCATION Langleyne Rocks, Pa	
33. FUNERAL DIRECTOR NAME Paul A. Couch		ADDRESS North East, Md.		34. DATE REC'D. BY REGISTRAR SEP 1 1982		REG. NO. 100-100-100 REGISTRAR'S SIGNATURE John J. Connell	

BP \_\_\_\_\_  
DMMH-17  
VR A15 ME (5)

DHMH - 17  
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 1 1 5 1											
1a DECEASED NAME (TYPE OR PRINT)				1b FIRST		1c MIDDLE		1d LAST		2a DATE OF DEATH		2b MONTH	2c DAY	2d YEAR	2e HOUR				
WARNER				C.				MOORE		AUGUST 14, 1982					a. m.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.									
Male		White		May 11, 1891		91 yrs													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Maryland		USA				Cecil		North East		110 Mechanics Valley Road		Custodian- Cecil		Board County School					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME FIRST		15. MOTHER'S MAIDEN NAME FIRST		LAST					
Maryland		Cecil		North East		YES <input checked="" type="checkbox"/>		110 Mechanics Valley Road		Theodore		Annie		McDowell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		ADDRESS		19. MEDICAL CERTIFICATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		219-05-5606		Mr. Ernest Trimble, North East, Md.		4280													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		19. MEDICAL CERTIFICATION		20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22. DATE SIGNED 8-16-82					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (was) attended the deceased from 11-21-1981 to 8-14-1982, that (I) (was) last seen the deceased alive on 8-13-1982, and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.		22b. SIGNATURE Luis M. Cuza, M.D.		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 322 E. Cecil Ave North East, Md 21901		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-16-82		23c. NAME OF CEMETERY OR CREMATORIAL Rosebank Cemetery		23d. LOCATION CITY OR TOWN Calvert		23e. COUNTY Maryland	
24. FUNERAL DIRECTOR HICKS HOME for FUNERALS, ELKTON, MD.		25a. DATE REC'D. BY REGISTRAR AUG 23 1982		25b. REGISTRAR'S SIGNATURE John & Canfield															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the other death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	2	1	1	5	2
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)	FIRST		MIDDLE		LAST		2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR						
STEPHEN J. OZAROWSKI							August 6, 1982					11:45am						
1. SEX <i>MALE</i>	4 RACE <i>white</i>		5 DATE OF BIRTH MONTH <i>7</i>		DAY <i>23</i>	YEAR <i>1911</i>	6 AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS <i>7</i>		IF UNDER 24 HRS DAYS <i>1</i>							
7. BIRTHPLACE COUNTRY <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CECIL COUNTY MD</i>													
10. CITY OR TOWN OF DEATH <i>Perry Point, Md.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>VA Medical Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SALESMAN</i>						12b. KIND OF BUSINESS OR INDUSTRY <i>Cannondale SHOE</i>									
13. STATE <i>md</i>	13b. COUNTY		13c. CITY OR TOWN <i>BALTO</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>515 S. WOLFE ST</i>											
14. FATHER'S NAME <i>WALTER</i>	MIDDLE		LAST <i>OZAROWSKI</i>		15. MOTHER'S MAIDEN NAME <i>ANTOINETTE</i>		16. SOCIAL SECURITY NO <i>212-03-7522</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <i>YES</i>	16b. IF YES, GIVE WAR OR DATES <i>WW II</i>		17. INFORMANT <i>THEODORE OZAROWSKI</i>		17. ADDRESS <i>321 S. ELRIO ST</i>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4379</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Aspiratory failure</i>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral vascular insufficiency</i>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (in this hospital) attended the deceased from <i>May 17, 1982</i> to <i>August 6, 1982</i> <i>xxxxxx</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Julian Ocejo, M.D.</i> DEGREE												22c. DATE SIGNED <i>8-6-82</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JULIAN OCEJO, M.D.</i>			22e. ADDRESS <i>VA Medical Center, Perry Point, Md.</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>8-10-82</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>HOLY ROSARY</i>			23d. LOCATION CITY OR TOWN <i>BALTO</i>			COUNTY		STATE <i>md</i>				
24. FUNERAL DIRECTOR NAME <i>John M. Weber Funeral Home, Baltimore, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 09 1982</i>									25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>						

## Lesson 10: My Major Concepts

2025 RELEASE UNDER E.O. 14176

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### Artist websites

## Geometric aspects of the metric

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• In 1999, the World Health Assembly

www.english-test.net

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	2	1	1	5	3
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST Agnes K.			MIDDLE Palmer			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH 5 DAY 19 YEAR 14			68			MONTHS	YEARS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH							
Md. Va.			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Elkton			Union Hospital of Cecil County										Homemaker			
13a. STATE Md.			13b. COUNTY Cecil			13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS #2 Hollingsworth Manor				
14. FATHER'S NAME FIRST Henry			MIDDLE -			LAST Collins			15. MOTHER'S MAIDEN NAME FIRST Willie			MIDDLE Linnie		LAST McCraw		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			ADDRESS				
No			232-28-8745			Mrs. Peggy Wegert, Elkton, Md.			Myocardial Infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1419			Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost			(b) Ca - Tongue with Metastasis.			DUE TO, OR AS A CONSEQUENCE OF							
1419						(c)			DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/31 19 82 to 8/31 19 82, that (I) (we) last saw the deceased alive on 8/31 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Sheelman S. Sachda			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8.3.82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Elkton, Maryland 21921													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-6-82			23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Methodist Cemetery			23d. LOCATION CITY OR TOWN							
24. FUNERAL DIRECTOR NAME HICKS			ADDRESS HOME for FUNERALS, ELKTON, MD.			25a. DATE REC'D. BY REGISTRAR AUG 11 1982			COUNTY							
									STATE							

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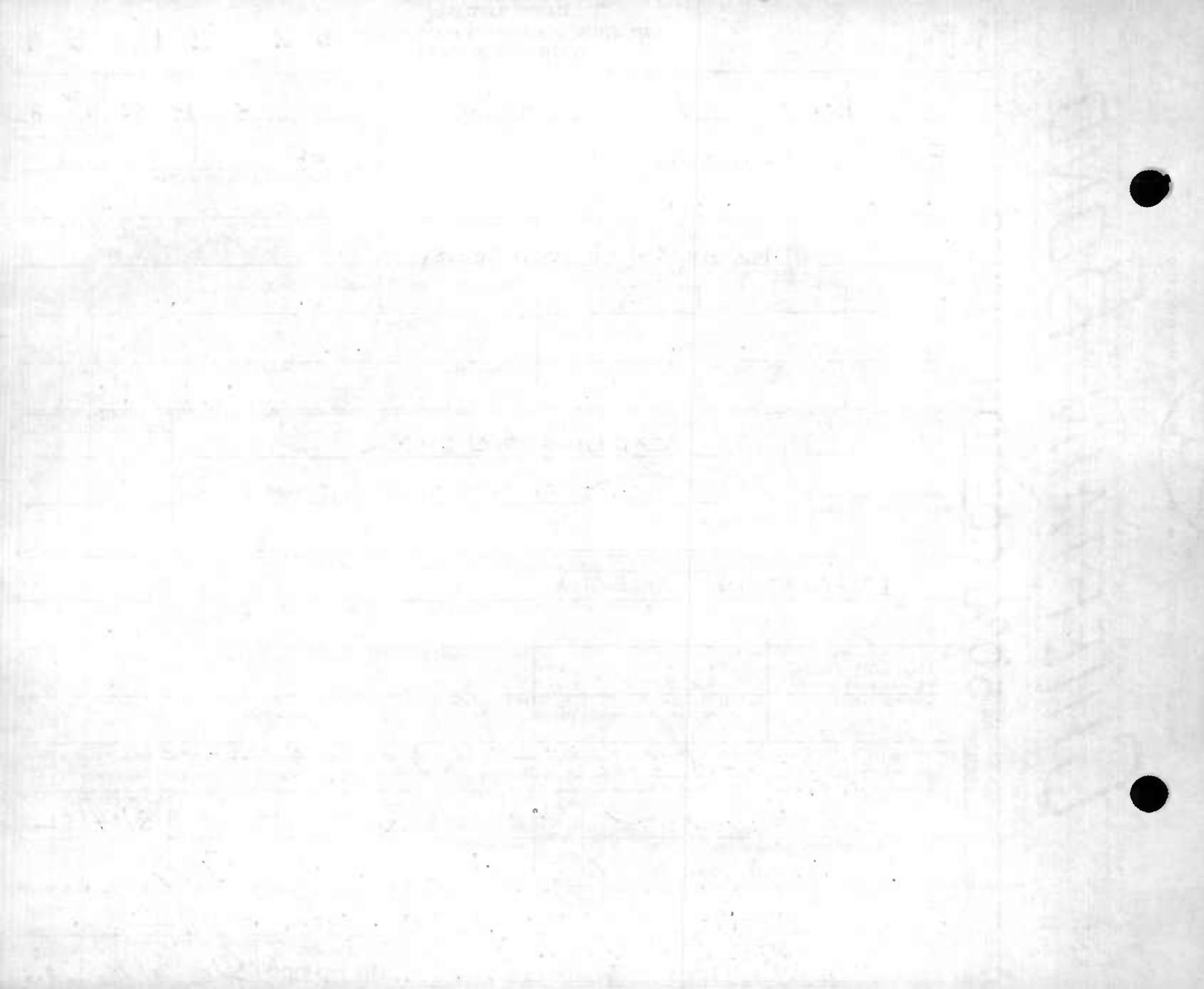
elsewhere

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8221154				
REG. NO.																
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Azea			V Phillips						8 14 82			9:38 AM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female			Caucasian			9 11 65			66 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
W. Va.			U.S.A.						Cecil Co.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Elkton			Union Hospital of Cecil County			Housewife			Home							
13a. STATE Md.			13b. COUNTY Cecil			13c. CITY OR TOWN North East			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 207 N. Main St.				
14. FATHER'S NAME Christopher W. Slack						15. MOTHER'S MAIDEN NAME Winnie S. Thomas										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 236-54-0105			17. INFORMANT James Phillips			ADDRESS 207 N. Main St. North East, Md.							
NO																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any																
(b) <b>ACUTE MYOCARDIAL INFARCTION</b>																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>EMACIATION, ANEMIA</b>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 8-8- to 8-13- 1982, that (I) (we) last saw the deceased alive on 8-13- 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <i>E. Rahman</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/14/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Rahman, M.D.			22e. ADDRESS Newark Del.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-17-82			23c. NAME OF CEMETERY OR CREMATORIAL North East Meth.			23d. LOCATION CITY OR TOWN North East Cecil Md.							
24. FUNERAL DIRECTOR NAME Robert J. Crouch			ADDRESS Crouch Funeral Home North East			25a. DATE REC'D. BY REGISTRAR AUG 18 1982			25b. REGISTRAR'S SIGNATURE See J. Crouch							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 2 1 1 5 5							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Florence A. Tingley						8/23/82						3:30 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS							
Female		White		Month Day Year			82			MONTHS	YEARS	MONTHS	HOURS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE-CITY OR COUNTY OF DEATH			MD.									
Pennsylvania		USA					Cecil Co												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Elkton		Union Hospital			Inspector			Health Dept.											
13a. STATE Maryland												13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 112 Arundel Lane	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																	
Albert J. Rauch		Bertha A. George																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		184-01-9538 A		Pamela Schoch, Elkton, Md. 21920															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary Respiratory arrest</u>																			
1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>Cancer of the Breast</u>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) this hospital) attended the deceased from <u>July 18, 1982</u> , to <u>August 23, 1982</u> , that (I) (we) last saw the deceased alive on <u>Aug 22, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE			22c. DATE SIGNED														
<u>Charles M. Hensgen, M.D.</u>																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS														
Charles M. Hensgen, M.D.					North East Md														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE									
Cremation		8-26-82		Cratin and Ferris Crematory, West Chester, Pa.															
24. FUNERAL DIRECTOR NAME HICKS HOME FOR FUNERALS, ELKTON, MD.		ADDRESS			25a. DATE BORN BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
<u>Ralph E. Hicks</u>					Aug 30, 1982														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be informed and advised.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	2	1	1	5	6	
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
GEORGE H RICKS									August 31, 1982						4:10am M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
male			Black			MONTH DAY YEAR			87			MONTHS	YEARS	MONTHS	YEARS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Va.			USA									Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Perry Point, Md.			VA Medical Center														
13a. STATE			13b. COUNTY			13c. CITY, OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md.			Harford			Aberdeen			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			754 Battle Ave.					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME											
Arthur			Ricks			Mattice											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
yes			218-54-0363			Catherine Battle			Same as above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
1629 IMMEDIATE CAUSE (a) 1629										Bronchopneumonia, bilateral							
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of right lung																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
Amyotrophic lateral sclerosis (clinical)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that <input checked="" type="checkbox"/> (the hospital) attended the deceased from August 12, 1982, to August 31, 1982, XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE M. N. ATAY, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9-1-82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			VA Medical Center, Perry Point, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9-3-82			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary			23d. LOCATION CITY OR TOWN			COUNTY			STATE		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE SEP 3 1982 John J. Conigli											
Beard Funeral Home, Havre de Grace, Md.																	

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C. J. YOUNG

Based on the role, have a look at the following table:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

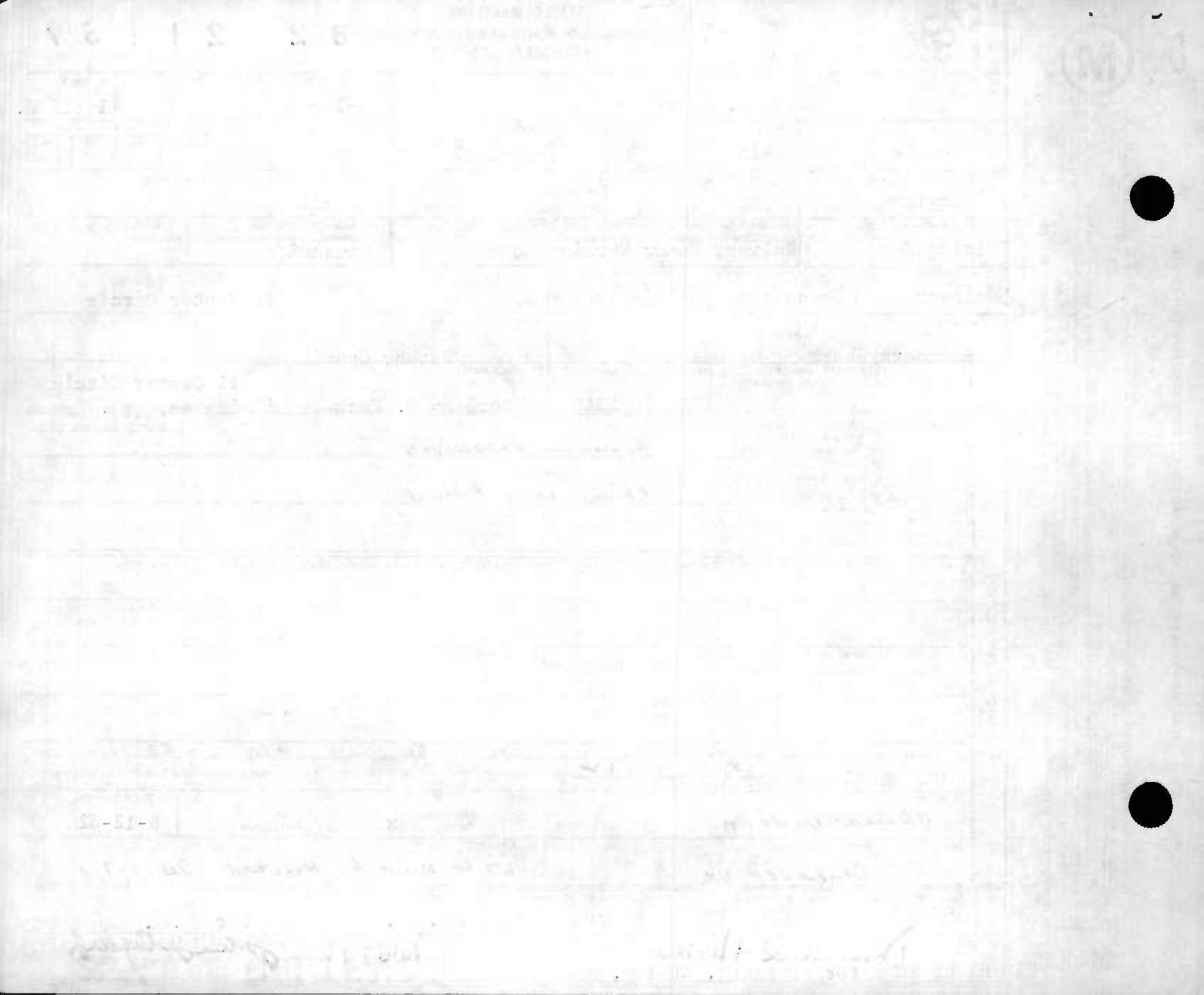
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 2 2 1 1 5 7							
						REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Laura O. Roark						8-11-82				10:15 P.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH 01-26-1887 DAY YEAR		95		MONTHS YRS		DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Maryland		USA				Cecil							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Rising Sun		Calvert Manor Nursing Home		Housewife									
13a. STATE Delaware						13b. COUNTY Newcastle		13c. CITY OR TOWN Wilmington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11 Center Circle	
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE				
Saunders Shank						Esther Cunningham							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no			221 50 6340			Dorothy H. Peck			11 Center Circle				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						Aspiration Pneumonia							
5188 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) Cholec. Lucy disease							
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/11 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE J.R. Dearworth Jr.		DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) J.R. Dearworth Jr.		22e. ADDRESS 167 W. Main St. Newark, Del. 19711						22d. DATE SIGNED 8-12-82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 14 Aug 82		23c. NAME OF CEMETERY OR CREMATORIUM Gracelawn Mem. Pk.		23d. LOCATION CITY OR TOWN New Castle N.C.		COUNTY		STATE Delaware			
24. FUNERAL DIRECTOR NAME Donald S. Hicks HICKS HOME FOR FUNERALS, ELKTON, MD		25a. DATE REC'D. BY REGISTRAR AUG 17 1982 John J. Cawley						REGISTRATION NUMBER 1051745					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	2	1	1	5	8		
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
MABEL			I.			.			SKINNER			AUGUST			28	1982		1:40 p.m.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Female			White			MONTH DAY YEAR			83			Virginia			June 14, 1899			Cecil		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. USA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Virginia			USA			Laurelwood Nursing Center			Homemaker											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Elkton			Laurelwood Nursing Center																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Delaware			New Castle			Claymont			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			17 Drexel Road								
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME														
William			W. Bunch			Elizabeth												LAST Crawford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No			217-36-3608			Mrs. Sarah I. Davis, Claymont, Del. 19703														
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c)												PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a)												2639 <i>Senility Cardi-pulm. failure</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Diseases								
DUE TO, OR AS CONSEQUENCE OF (b) <i>Senility</i>																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) <input type="checkbox"/> (we) <input type="checkbox"/> attended the deceased from <i>8-28 1982</i> to <i>8-28 1982</i> , and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) <input type="checkbox"/> view the body after death.												22c. DATE SIGNED 8-31-82								
22b. SIGNATURE <i>Donald C. Edger MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD C. EDGER</i>			22e. ADDRESS 721 Bridge Street, Elkton, Md. 21921								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-1-82			23c. NAME OF CEMETERY OR CREMATORIAL Sharps Cemetery			23d. LOCATION CITY OR TOWN Fair Hill, Maryland			COUNTY			STATE					
24. FUNERAL DIRECTOR NAME <i>Donald S. Hicks</i>			ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.			25a. DATE REC'D. BY REGISTRAR SEP 9 1982			25b. REGISTRAR'S SIGNATURE <i>John L. Daniels</i>											

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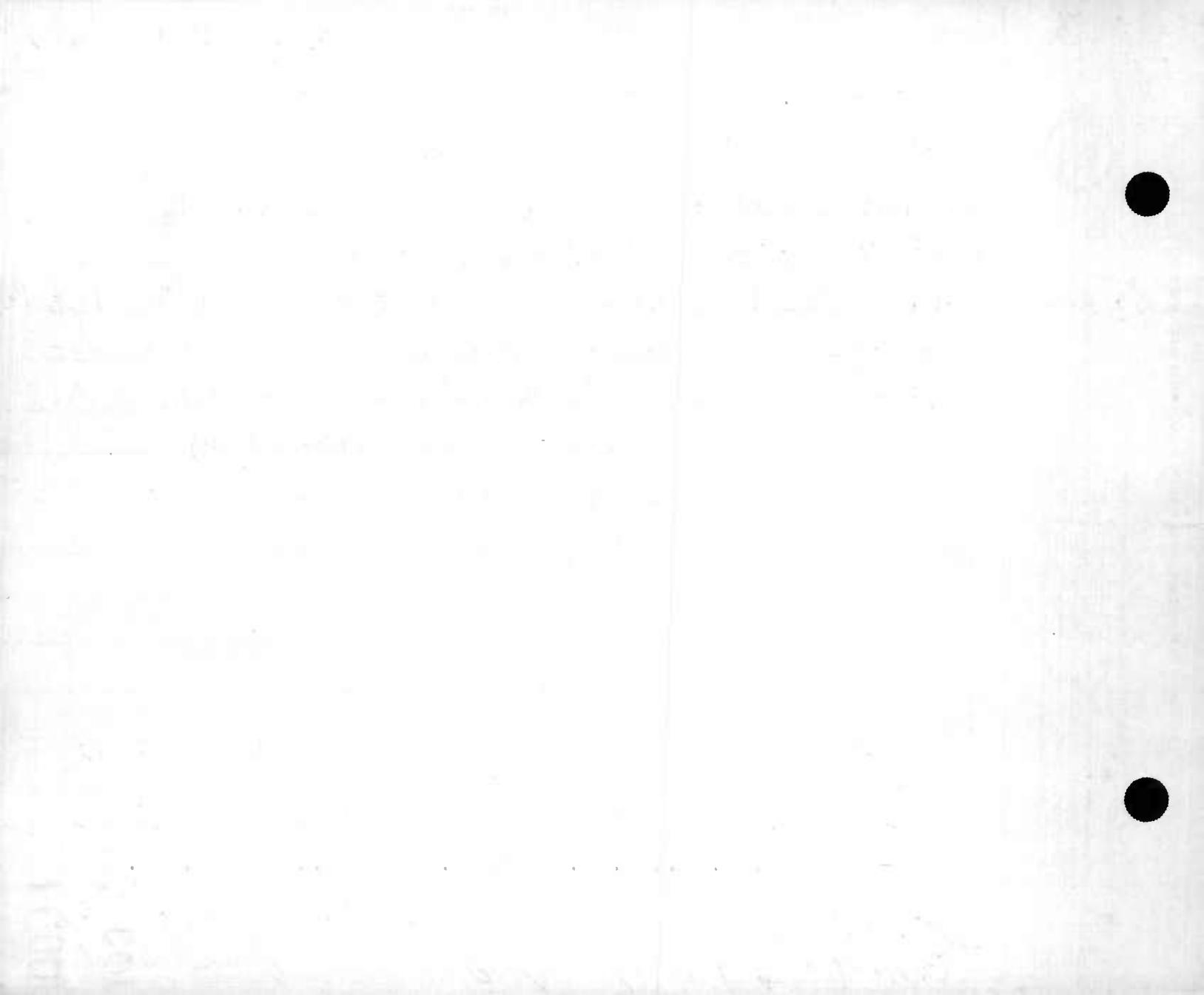
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8221159				
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Fleta E.						Slaten						8/1/82				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
female			white			MONTH DAY YEAR			95			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Illinois			U.S.A.						Cecil County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
EIKTON			38 Hillcrest Ct. Manchester Pk.						Housewife							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Md.			Cecil			Elkton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			38 Hillcrest Ct. Manchester Pk.				
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME							
			George			Berry			Miriam			McKenzie				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			171-26-3861			Mrs John P. SLATEN, Jr			EIKTON, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)																
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ca of colon.</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASVD</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from <u>6/30/82</u> to <u>8/1/82</u> , that (I) (we) last saw the deceased alive on <u>6/30/82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8-3-82				
22b. SIGNATURE <u>Jui-Chih Hsu</u> MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui-Chih Hsu, M. D., P. A.			22e. ADDRESS 223 W. Main St., Elkton, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 8-5-82			23c. NAME OF CEMETERY OR CREMATORIAL X to rd Cemetery			23d. LOCATION CITY OR TOWN Oxford Chester Pa.							
24. FUNERAL DIRECTOR ADDRESS									25a. DATE REC'D. BY REGISTRAR AUG 6 1982			25b. REGISTRAR'S SIGNATURE John J. Conner				

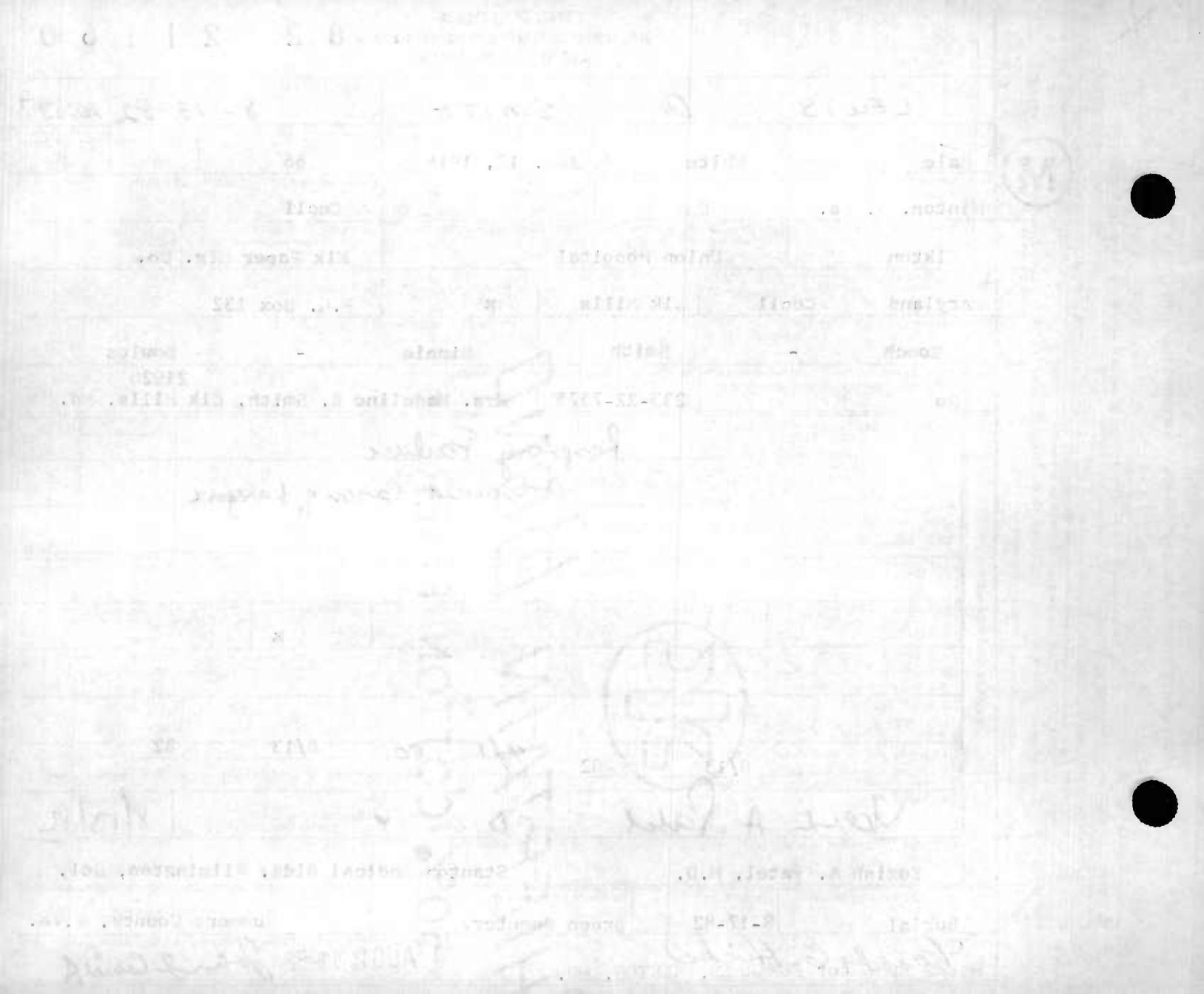


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	2	1	1	6	0	
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR					
LEWIS			O.	SMITH		8-13-82						10:53 A M					
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White		JAN. 18, 1916			66			YRS	MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Hinton, W. Va.			USA					Cecil									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Elkton			Union Hospital			Elk Paper Mfg. Co.											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS								
Maryland		Cecil		Elk Mills					P.O. Box 132								
14 FATHER'S NAME FIRST			MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST								
Gooch			-	Smith	Minnie			-	Bowles								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			233-22-7575			Mrs. Madeline R. Smith, Elk Mills, Md.			21920								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
1619 Respiratory Failure																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DOUE TO, OR AS A CONSEQUENCE OF (b)										Advanced Cancer of Larynx							
DOUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/13/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			4/1, 1980			to 8/13, 1982											
22b. SIGNATURE Yogish A. Patel			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/13/82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Stanton Medical Bldg. Wilmington, Del.											
Yogish A. Patel, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY STATE						
Burial			8-17-82		Breen Cemetery			Summers County, W.Va.									
24. FUNERAL DIRECTOR HICKS HOME FOR FUNERALS, ELKTON, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE								
						AUG 23 1982			John J. Conigli								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 1 1 6 1	
				REG. NO.	
1. FOR STATE REGISTRAR	FIRST <b>HARVEY</b>	MIDDLE <b>L.</b>	LAST <b>SOUTTER</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>August 28, 1982</b>	
3. SEX <b>male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 1, 1926</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	8. IF UNDER 24 HRS HOURS <b>10</b> MIN. <b>20pm</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>	MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Woodcutter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Wood</b>		
13a. STATE <b>Virginia</b>	13b. COUNTY <b>Culpeper</b>	13c. CITY OR TOWN <b>Culpeper</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Rt. 4, Box 391</b>	22701
14. FATHER'S NAME FIRST <b>Hezekiah</b>	MIDDLE <b>Bernard</b>	LAST <b>Soutter</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Nannie Elizabeth</b>	MIDDLE <b>Byram</b>	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) <b>W. W. II</b>	16c. 226-26-2241	17. INFORMANT <b>Evelina Carpenter</b>	ADDRESS <b>SR 4, Box 170 Brightwood, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4140</b> Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute pulmonary edema, severe</b>					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic coronary artery disease, severe</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1/0					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 4, 1982</b> to <b>August 28, 1982</b> <b>XXXXXXXXXX</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not) did not view the body at the time of death.					
22b. SIGNATURE <i>Abdul Karim</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>8-30-82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL KARIM, M.D.</b>	22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>	23b. DATE <b>9/1/82</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Culpeper National</b>	23d. LOCATION CITY OR TOWN <b>Culpeper</b>	23e. COUNTY <b>Culpeper</b>	STATE <b>Va.</b>
24. FUNERAL DIRECTOR NAME <b>Geest-Johnson Funeral Home, Culpeper, VA.</b>	ADDRESS	25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1982</b>	25b. REGISTRAR'S SIGNATURE <i>John J. Cawley</i>		
DHMH - 16 50M 1/81 (VRA 15, 4)					

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P. 9. P.

1960, 1961, 1962

Page 40-200

GENDER CONSTRUCTION IN MIGRATION

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“*Revolving door*” *entrepreneurial* *cohort* *process*?

3

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S. J. - 100 - 2

2

• 54. *What does the following sentence mean?*

• "The sequence of events from the beginning of the game to the end of the game is called a game history."

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be

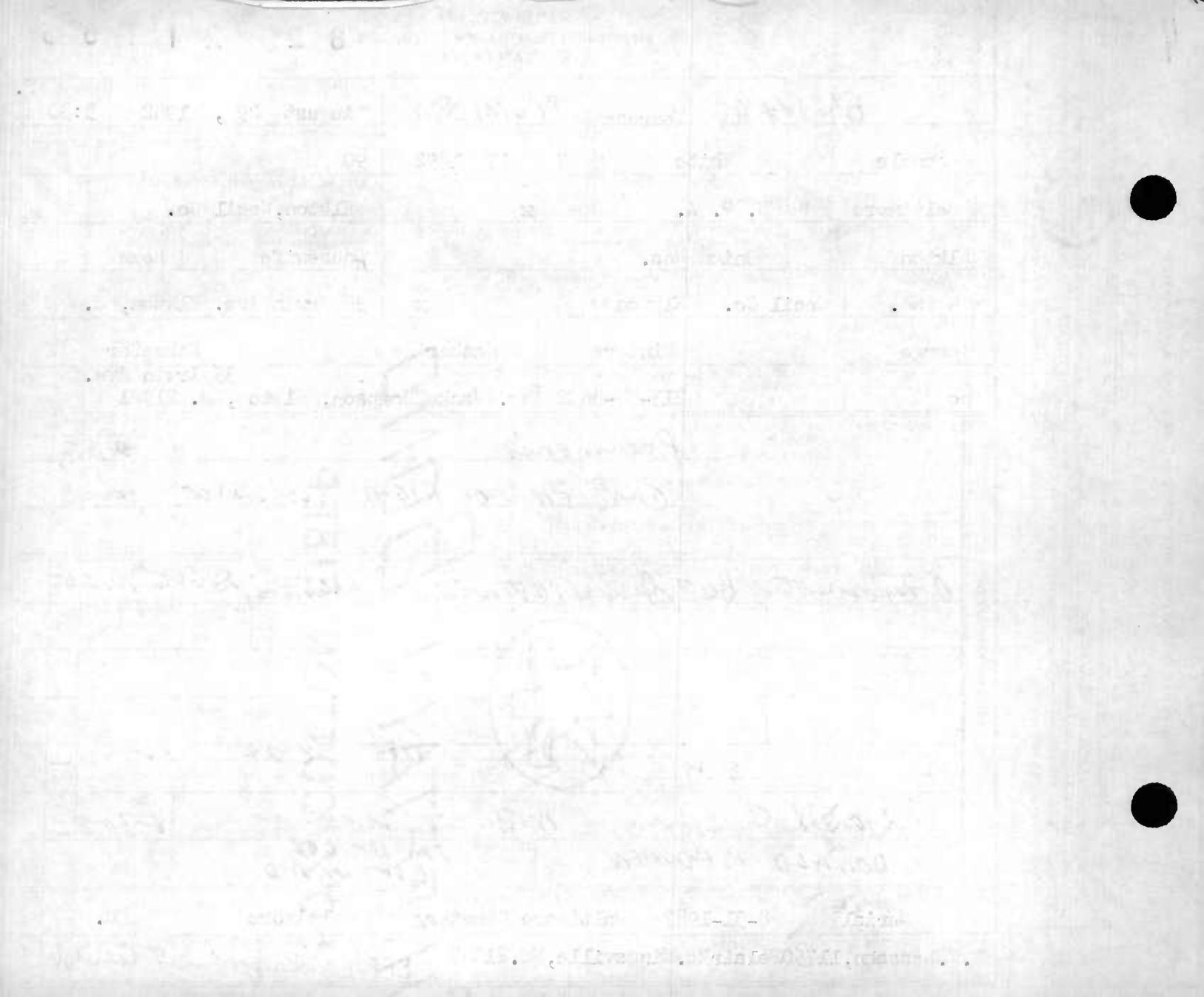
reborned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, then please remove carbon paper. Page 1 and 2 should be filled in by the physician. Page 3 should be filled in by the funeral director. Page 3 should be filled in by the funeral director. Page 3 should be filled in by the funeral director. Page 3 should be filled in by the funeral director. Page 3 should be filled in by the funeral director.

IMPORTANT: If Item 21a is marked on Item 18, then any injury, or other traumatic event, in medical history, should be marked on Item 21a.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 1 1 6 3			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR P.	
BARBARA Theresa THOMPSON						August 29, 1982						3:30 M	
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR		
Female			White			7 27 1892			7	27	1892		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	
Baltimore			U. S. A.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Elkton			Union Hos.			Housewife			home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS				
Md.	Cecil Co.	Elkton				YES	NO		35 Irwin Ave. Elkton, Md.				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			LAST				
George			Winters			Catherine			Schaefer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
no			213-74-8802			Mr. Jack Thompson, Elkton, Md. 21921			35 Irwin Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Pneumonia 7 4860										3 days			
DUE TO, OR AS A CONSEQUENCE OF (b) GANGRENE OF RIGHT TOE AND FOOT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										lived			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterosclerotic Heart Disease, Arteriosclerotic Obstruction, Diabetes Mellitus													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8-28 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Donald C. Edgren										DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8-30-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD C. EDGREN			22e. ADDRESS 721 BRIDGE ELKTON, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-31-1982			23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery			23d. LOCATION CITY/TOWNSHIP Baltimore			STATE Md.	
24. FUNERAL DIRECTOR E.F. Tassahn, 11750 Belair Rd. Kingsville, Md. 21087										25a. DATE REC'D. BY REGISTRAR SEP 7 1982			25b. REGISTRAR'S SIGNATURE John J. Conard



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. *Page 4 may be retained by the hospital or attending physician.*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 2 2 1 1 6 2	REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
<i>Garland</i>			<i>S. Stroupe</i>			8 5 1982					9:10 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		May 9, 1927		55		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		YRS.			
Va.		U.S.A.				<i>Cecil Co</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BIRTH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK AND NUMBER OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Elkton		Union Hosp.				Operator		Indu.			
13a. STATE		13b. COUNTY		14. FATHER'S NAME		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		LAST	
Md.		Cecil		Stephen P. Stroupe		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		P.O. Box 179			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
No		227-28-4404		Mary Stroupe		P.O. Box 179 Charlestown		Md.			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>7/22</i> , 19 <i>82</i> , to <i>8/5</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>8/5</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Rahman</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EHSANUR RAHMAN</i>		22e. ADDRESS <i>314 E. MAIN ST., NEWARK, DE 19711</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>8-6-82</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Silverbrook</i>		23d. LOCATION CITY OR TOWN <i>Wilmington, New Castle, Del.</i>		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Robert J. Clark</i>		ADDRESS <i>North East, Md.</i>		25a. DATE FILED BY <i>AUG 9 1982</i>		25b. REGISTRAR'S SIGNATURE <i>J. New Castle, Del.</i>					
BP _____											
DHMH-16 30M 2/80 (VRA 15, 4)											

